A HISTORY OF THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH 1962—1977

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State of Illinois
JAMES THOMPSON, *Governor*
1983

This book was written in 1977 as part of the observance of the Illinois Department of Public Health Centennial. It is the third in a series of Department histories. The first book, *The Rise and Fall of Disease in Illinois*, is a two-volume history written in 1927, documenting the Department's first 50 years.

The second, entitled *A History of the Department of Public Health*, covers the period 1927 through 1962.

Events that occurred after 1977 are not included in this book.

FRANKLIN D. YODER, M.D.
Sept. 1, 1961–Feb. 18, 1973

JOYCE C. LASHOF, M.D.
Feb. 19, 1973–Feb. 8, 1977

PAUL Q. PETERSON, M.D., M.P.H.
March 1, 1977–Present

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INTRODUCTION

THE PURPOSE OF THIS VOLUME is to update the written history of the Illinois Department of Public Health through the year 1977, its Centennial Birthday.

The story of the state's health agency, from its beginning as a Board of Health in 1877, is contained in a two-volume work entitled *The Rise and Fall of Disease in Illinois*, published in 1927, and a single volume work entitled *A History of the Illinois Department of Public Health, 1927–1962.* For the reader interested in the early history of the department, these volumes are available at the Illinois State Library.

All three of these volumes are the work of Baxter K. Richardson, whose employment by the department covered a period of more than forty years and whose dedication to public health and to the department earned for him the justifiable title of Mr. Public Health.

The original statute creating the Illinois State Board of Health in 1877 remains in effect in 1977 with only slight modifications to its basic intent. It reposes in the department, as it did in the state board of health, the authority "to have the general supervision of the interests of the health and lives of the people of the state." To that broad declaration there have been added, over the years, numerous specific statutes relating to the department's authority and responsibilities and, especially, the so-called Civil Administrative Code.

In 1917, during the administration of Governor Lowden, the executive branch of Illinois State government was reorganized. Authority, duties, activities, and responsibilities of related natures were codified and vested in specific code departments. Thus, the state board of health became the Illinois Department of Public Health. Instead of a seven-member board to administer the health affairs of the state, this responsibility was placed upon one person, the director of public health, appointed by the governor with the advice and consent of the senate. Each department director is a member of the governor's cabinet.

By statute, the person appointed as the director of public health was required to have a license to practice medicine and surgery in Illinois. Subsequently, as the science of public health progressed, a minimum number of years of medical practice became an added requirement, as well as a minimum number of years of public health experience. In 1961, there was added to these qualifications a required possession of a master's degree in public health and certification by the American Board of Preventive Medicine in Public Health.

The Civil Administrative Code, adopted in 1917, created the State Board of Public Health Advisors. The requirement that the governor appoint such a board remains in effect.

The State Board of Public Health Advisors has authority to advise the director *upon his request*; to recommend, on its own initiative, policies and practices the director is obligated to *consider*; to give advice or make recommendations to the governor and the general assembly *when so requested*; to investigate, on its own initiative, the conduct of the work of the department; and to hold meetings whenever and wherever within the state it may determine, but not less frequently than quarterly.

The desirability of a historical record to follow *A History of the Illinois Department of Public Health, 1927–1962* was recognized following the publication of that volume. Toward that end, the author and Mr. Forrest Nelson, a long-time employee and public health educator, worked out a procedure for collecting and preserving various materials having historical value. After many years of collecting, a fire completely razed the department's Industrial Park installation where the records were stored. Without these valuable resources, it must be presumed that some accounts of noteworthy events and activities have been lost to this historical record. Another problem encountered is the absence of printed annual reports from fiscal year ending 1973 to date. This omission presented a troublesome handicap in researching the data for the period involved.

The period covered by the pages that follow involves three directors of public health, each of whom has been a major factor in influencing the department's administration, accomplishments, and stature:

Franklin D. Yoder, M.D., M.P.H., September 1, 1961 – February 18, 1973

Joyce C. Lashof, M.D., February 19, 1973 – February 8, 1977

Paul Q. Peterson, M.D., M.P.H., March 1, 1977 – present

Chapter 1

ORGANIZATION AND PERSONNEL

THE YODER ADMINISTRATION

In the previous volume, *The History of the Illinois Department of Public Health, 1927–1962*, references to the Yoder administration were necessarily limited since that administration was in its infancy at that time. For completeness herein, some of the previous observations bear repetition.

A native of Wyoming, with a rich background of experience in medical, public health and educational affairs, Franklin D. Yoder, M.D., M.P.H., was appointed as director of public health by Governor Otto Kerner on September 1, 1961. A graduate of Northwestern Medical College in 1939 and the School of Public Health of the University of California in 1948, Doctor Yoder had employment experience that included five years of private practice; three years as flight surgeon in the army; ten years as director of the Wyoming Department of Public Health; and two years as director of the Division of Environmental Health of the American Medical Association. Other background activities included eight years as a member of the Western Interstate Commission for Higher Education; three years as secretary/treasurer and one as president of the Association of State and Territorial Health Officers; and faculty assignments at the University of Wyoming, Northwestern University, and the University of Illinois.

Doctor Yoder brought a dynamic personality and an infectious enthusiasm to the department to give it renewed vigor. The department had reached a turning point. The public health program had reached, or was approaching, the goals that it had originally been designed to achieve while its leadership vacillated. Slowly but surely

the wheels of progress were coming to a halt. The gloom that pervaded the staff began to lift when it learned of Doctor Yoder's appointment. While few members of the staff had heard of him, all were in agreement that his educational background and experience merited their welcome—with reservations, of course.

Dr. Yoder began his directorship without "a new broom." The first six months may be characterized as a "shakedown cruise" wherein the captain was cautious and observant while getting personally acquainted with his staff's performances, and learning the policies, principles, and precedents, mostly unwritten, that had become major factors in the operation of the department. From the beginning of his directorship, however, he exuded optimism in the future of the Illinois public health service and transmitted this confidence to his staff. He initiated weekly staff meetings at which attendance was required and during which he tactfully, but positively, made known the directions and attainments he expected of the various programs and services. A series of consultations were held with each program and service director wherein accomplishments and objectives were targeted for attainment within a specified span of time.

By the end of 1962, he had reactivated, through Governor Kerner, the State Board of Health Advisors, which had held three fruitful meetings. Early in 1962, he had designated a long-time employee of the department, E. L. Wittenborn, as assistant to the director and made other changes in order to take better advantage of program and administrative talents. He increased considerably the financial commitments from federal grants to local communities for initiating or expanding chronic ailment projects and for qualifying individuals for specialized training in that field. He established favorable relations with various agencies, official and voluntary, having direct interests in the public health program and, most important of all, brought about a high level of morale and esprit de corps among the department's personnel.

Governor Kerner took office in January, 1961, but postponed the appointment of a new director of public health until September of that year after having held an eight-month search that resulted in Doctor Yoder's appointment. The governor adopted a system of departmental liaisons with his office in order to ease the burden of administration caused by an overbroad span of control (a problem common to big government). A young Springfield attorney, Dale Yung, was assigned to the Department of Public Health. This was a fortunate circumstance since Mr. Yung was knowledgeable concerning Illinois governmental affairs and statutes and the policies of the Kerner administration, yet recognized his limited knowledge of

public health and its principles. His open-mindedness and open door gave the director and his assistant ready access to advice and direction in matters of administration, legislation, budget, and personnel. His position in no way precluded the director's access to the governor when considered necessary. This arrangement, by virtue of the personalities involved, proved to be successful and effective. When Governor Kerner resigned to accept appointment as a federal judge, the same arrangement continued under Governor Samuel Shapiro, a long-time friend and supporter of public health in his capacity both as lieutenant governor and as a member of the general assembly.

In 1968, Governor Shapiro was defeated for office by the former sheriff of Cook County, Richard B. Ogilvie. Among his first official gubernatorial actions was the reappointment of Doctor Yoder as director of the department, an action recommended and sponsored by the Illinois State Medical Society and the Illinois State Dental Society. He was again readily confirmed by the senate.

Following Governor Kerner's precedent, Governor Ogilive also employed departmental liaisons and named a young man, John Daley, to the Department of Public Health.

In March of 1971, the governor appointed a young physician, Bruce A. Flashner, M.D., as deputy director. Without formal training in public health, the title "assistant director" could not be used because of the statute requiring a master's degree in public health.

With the election of Governor Walker in 1972, a number of major health organizations attempted to recommend the continuance of Doctor Yoder in the directorship. On February 18, 1973, Doctor Yoder resigned after more than eleven years as director of public health—eleven years of progress and accomplishment. Only one other director, Doctor Roland R. Cross, had served a longer period in this position.

Organization and Personnel

It is considered desirable herein to describe the types of organizational arrangements utilized by the department and to place on record the names of personnel who had responsibilities for major units. While this section may prove to be prosaic reading, it is intended to place in chronological order the changes that have taken place and is a matter of historical record.

When Doctor Yoder came to the directorship on September 1, 1961, the organization of the department looked about like that shown in the chart on page 7, but without the position entitled

"assistant to the director." On March 1, 1962, he established the position as previously noted. Simultaneously, he abolished the position of deputy director held by Roger F. Sondag, M.D., M.P.H., and appointed him as chief of the Division of Hospitals and Chronic Illness. This initial move proved highly successful and placed a well-qualified physician in a position where medical expertise was especially needed at the time.

The following listings are in accordance with the major functions of each unit. Name changes and transfer of placement within the organizational hierarchy will be noted, covering the period of the Yoder administration from 1961 to 1973.

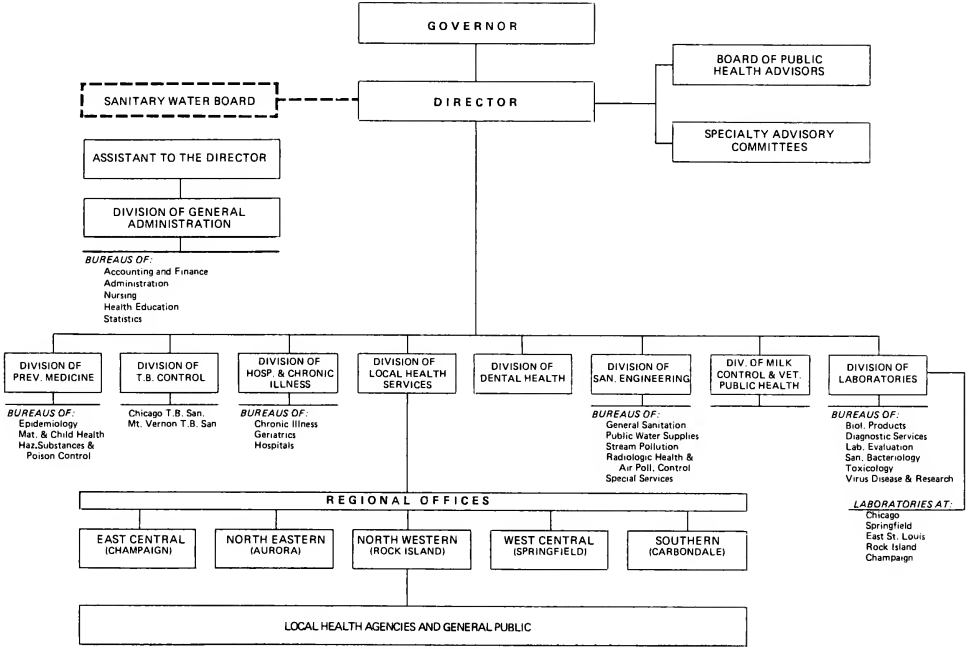
Division of General Administration

This unit is one that has always been closely allied with the director in its day-to-day operations. Over the years it became increasingly important, gradually becoming the unit from which all administrative and supportive services emanated.

In 1962, there were five bureaus within the Division of General Administration. They were the Bureaus of (1) Accounting and Finance, (2) Health Education, (3) Nursing, (4) Administration, and (5) Statistics. The placement of the Bureau of Nursing in this division can be accounted for on the basis of its being a support service, although it was not entirely acceptable to public health nurses who felt their contributions to public health merited status higher in the organization and a closer relationship with divisions having a medical orientation.

By early 1964, it became evident that the director needed some relief from an ever-increasing workload brought about by a department that was continually accelerating its activities. On April 1, 1964, the position of medical assistant to the director was established, and it was filled by Edward Press, M.D., M.P.H. Doctor Press came to the department from the National Commission on Community Health Services. Before that, he had been the director of the Evanston Health Department and an assistant professor of pediatrics at the Northwestern University School of Medicine. For a relatively short time, Doctor Press was headquartered in Springfield. However, the department's business in Chicago and its metropolitan area had reached the point where high level representation was needed there on a full-time basis. Offices were secured in the State of Illinois Building in downtown Chicago, and Doctor Press became the director's representative in the Chicago metropolitan area.

After many years of insistence by the Legislative Audit Commis-



ORGANIZATION AS OF MARCH 1, 1962

sion, the department, on March 15, 1967, employed an internal auditor who worked under the supervision of the assistant to the director. The governor had never, up to this time, encouraged the employment of an internal auditor.

On March 1, 1969, the General Services Section was established within the Bureau of Administration to handle such items as leases, housing arrangements, stores and shipping, mail, etc. On the same date, the Bureau of Statistics was reorganized. This bureau had served three main functions: (1) compilation and analysis of biostatistics, (2) registration and custodial care of vital records, and (3) electronic data processing. The latter two became the Bureau of Vital Records and the Bureau of Electronic Data Processing, respectively. These remained as bureaus in the Division of General Administration, while the biostatistical function was transferred to the Division of Health Planning and Resource Development, which had been established in February, 1967.

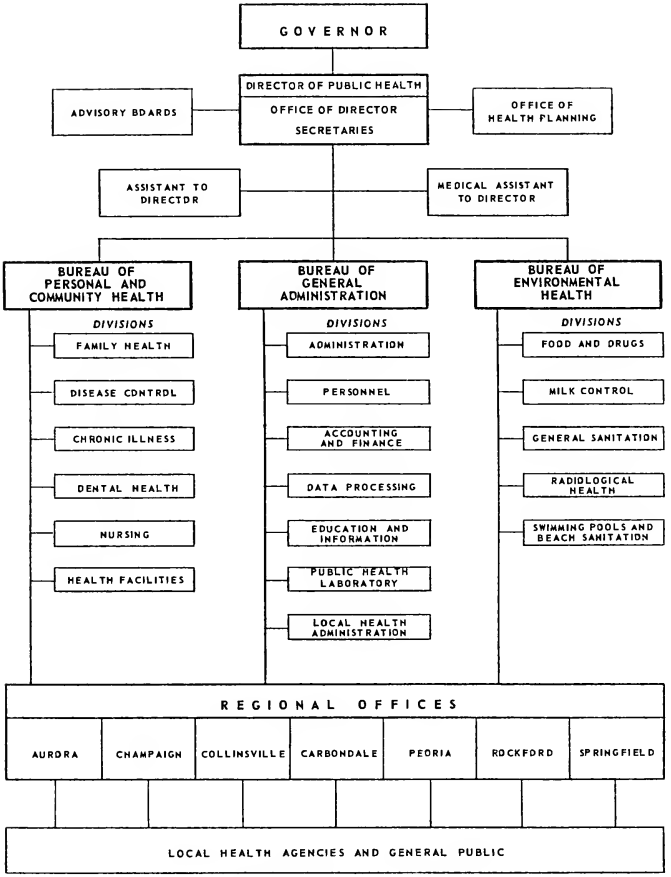
After months of study, the director announced a sweeping reorganization on August 1, 1970 designed to bring about more efficient operation and effective administration. (See page 9.) The new structure consisted basically of three major bureaus. (It should be noted that the designations of "bureau" and "division" were reversed with respect to their chain of command within the hierarchy.) The new major units became the Bureaus of (1) General Administration, (2) Environmental Health, and (3) Personal and Community Health. This arrangement had, among others, the beneficial effect of reducing substantially the director's span of control and of allowing greater flexibility in the use of appropriated funds. Whereas nontransferable state funds were formerly appropriated to ten divisions, the new organizational arrangement reduced this to three bureaus.

The new Bureau of General Administration now embraced the Divisions of (1) Accounting and Finance, (2) Electronic Data Processing, (3) Education and Information, (4) Laboratories, (5) Local Health Administration, and (6) Administration. To the latter was added the former vital records unit, while the public health nursing unit became a division in the new Bureau of Personal and Community Health.

The following is a list of persons who headed the various units in General Administration during the Yoder years. The designation of "bureau" or "division" is purposely omitted to avoid unnecessary complexity.

General Administration

Eugene L. Wittenborn, M.P.H. (March 1, 1962–June 15, 1973)



ORGANIZATION AS OF AUGUST 31, 1970

Accounting and Finance (Budget and Fiscal as of 1970)

Robert T. Malone (July 1, 1941–May 17, 1968
Ira D. Shipley, Acting (May 17, 1968–June 30, 1969)
Walter DeWeese, Acting (June 30, 1969–September 23, 1969)
Walter DeWeese (September 23, 1969–May 1, 1975)
George Akehurst (May 1, 1975–present)

Electronic Data Processing

Isabelle Crawford, M.A. (August 1, 1967–February 1, 1971)
Thomas Stuckey, B.A. (May 1, 1971–present)

Health Education (Education and Information as of 1970)

Lynford L. Keyes, M.P.H. (July 16, 1961–June 30, 1971)
Stanley R. Miles, M.P.H. (August 1, 1971–present)

Statistics (replaced by Vital Records and Electronic Data Processing in 1969)

Eugene L. Wittenborn, Acting (December 3, 1959–February 28, 1969)

Nursing (to Bureau of Personal and Community Health in 1970)

Pearl Ahrenkiel, R.N., M.S. (August 31, 1956–June 30, 1969)
Grace Musselman, R.N., M.P.H., Acting (July 1, 1969–November 15, 1970)

Helen M. Bruening, R.N., M.P.H. (November 15, 1970–August 8, 1976)

Administration

Eugene L. Wittenborn, M.P.H. (November 1, 1950–September 30, 1970)

Edgar E. Diddams, M.S.P.H. (October 1,1970–December 1, 1971)

Leonard A. Kutilek, B.A. (December 1, 1971–March 1, 1974)

Vital Records

Leo A. Ozier (March 1, 1969–April 15, 1974)

(For many years, Mr. Ozier had been head of the Office of Vital Records while it was in the Bureau of Statistics. Subsequently, in 1970, it became a section in the Bureau of Administration. Long before 1969 and up to 1974, Mr. Ozier held the title of Deputy State Registrar.)

Division of Dental Health

This division, a separate unit reporting directly to the director up until 1970, became a division that year under the Bureau of Personal and Community Health. Following are the persons who headed the division during Dr. Yoder's tenure:

John E. Zur, D.D.S., M.P.H. (March 1, 1957–December 21, 1961)

Orvis S. Hoag, D.D.S., M.P.H. (June 1, 1962–July 31, 1962)

William J. Greek, D.D.S., M.P.H. (August 1, 1962–February 18, 1966)

Carl L. Sebelius, D.D.S., M.P.H. (March 1, 1966–April 17, 1975)

Division of Laboratories

This unit, also reporting directly to the director in 1961, as it had from its beginnings in 1904, became a division in the Bureau of General Administration with the reorganization in 1970. This was considered a logical arrangement in order to gather all supportive and direct services under one supervisory roof, thereby aiding in the unification and mutual integration of effort by all the department's service units. Up to that time, new program appropriations seldom took into account the additional costs of laboratory services that might be necessary to the program operation.

The following were responsible for the laboratory operation during the period of Dr. Yoder's directorship:

Howard J. Shaughnessy, Ph.D. (August 1, 1938–February 10, 1965)

George F. Forster, Ph.D. (February 10, 1965–May 29, 1967)

Richard A. Morrissey, M.P.H., Acting (May 29, 1967–October 30, 1967)

Richard A. Morrissey, M.P.H. (October 30, 1967–July 1, 1977)

Within the division, in 1961, were the following bureaus (which became sections in 1970) and the persons who headed up each one:

Diagnostic Services

George F. Forster, Ph.D. (also Assistant Chief)

Mary Louise Brown, M.S.

Laboratory Evaluation

Herbert E. McDaniels, Ph.D.

Robert G. Martinek, Pharm. D.

Sanitary Bacteriology

Joseph C. McCaffrey, M.P.H. (also Assistant Chief)

Robert M. Scott (also Assistant Chief)

Toxicology

Robert V. Blanke, Ph.D.

Frank F. Fiorese, Ph.D.

Virus Disease and Research
Richard A. Morrissey, M.P.H.

Biologic Products
John L. Neal, Ph.G.

Division of Local Health Services

This division, in 1961, also reported directly to the director and was, in theory, the unit through which all communications and directions from the program divisions were to be channeled to the regional offices of the department. While the single vertical line on the organizational chart from this division to the regions made a neat and precise presentation of channels, the actual situation was quite different. Program heads in Springfield generally dealt directly with their representatives in the field. In 1961, there were five regional offices, each headed by a physician with a master's degree in public health. During the course of Doctor Yoder's administration, these physicians either retired, died, or resigned. Strenuous recruiting for physician replacements brought few results. In the meantime, various regional engineers and public health nurses were given the additional assignment of "acting regional health officer." This arrangement was unsatisfactory to the regional staff so assigned and to their chiefs in Springfield.

In 1970, therefore, an attempt was made to correct this situation at the time of the reorganization. Since the reorganization produced three major bureaus, each of the three bureau chiefs appointed his own regional representative, forming an administrative triumvirate in each regional office. This proved to be no solution. The triumvirates frequently disagreed over regional administrative matters causing dissension within the regional staff. This was soon recognized in Springfield, and a revision was being planned when Doctor Yoder was replaced.

The reorganization of 1970 placed the Division of Local Health Services in the new Bureau of General Administration. Its name was changed to the Division of Local Health Administration, and the division was absolved of all responsibility for the regional offices. Its main purpose became one of providing administrative assistance to local health agencies.

The chief of this unit, from June 1, 1948, until his retirement on May 31, 1973, was Charles F. Sutton, M.D., M.P.H.

Division of Tuberculosis Control

Here is another major unit that, in 1961, reported only to the director. Although the primary function of this unit was the prevention of tuberculosis, it was assigned responsibility for operation of both the Chicago State and the Mount Vernon State Tuberculosis Sanitoriums when those facilities came into being. In the reorganization of 1970, the division's responsibilities were redistributed, with the prevention activities going to the Division of Chronic Illness and the administration of the sanatoriums to the Division of Health Facilities. Both of these divisions functioned under the Bureau of Personal and Community Health. For the first time since 1917, the word *tuberculosis* did not appear on a department organization chart, which tends to reflect the progress made in controlling a disease that at one time utilized almost one-half of the department appropriation of state funds.

Doctor Clifton Hall, who was appointed chief of the Division of Tuberculosis Control on January 15, 1945, became chief of the Division of Chronic Illness following the death of its former head, Doctor William J. Cassel, on July 14, 1970, and remained in that position until his retirement on January 14, 1972.

The physicians in charge of the two tuberculosis sanatoriums were titled "superintendent and medical director," and were as follows:

Chicago State Tuberculosis Sanitarium

Karl H. Pfuetze, M.D.

Herbert Neuhaus, M.D.

Mr. Vernon State Tuberculosis Sanitarium

Isadore Zaplosky, M.D.

Morris Zelman, M.D., Acting

Norman J. Rose, M.D., Acting

Herman C. Rogers, M.D., Director

Robert J. Dancey, M.D., Director

Division of Milk Control

This division, which had long been a bureau within the Division of Sanitary Engineering, was made a separate division in 1956 and given the name of Milk Control and Veterinary Public Health. The precise reason for, or logic in, establishing this function as a

separate division is neither a matter of record nor factual knowledge by anyone available at this writing. It was thought at the time, however, that it was done to give the program greater prestige and also at the behest of the milk industry.

On October 26, 1962, Doctor Yoder changed its name to the Division of Milk Control and, in 1963, assigned the veterinary public health function to what was then the Bureau of Epidemiology in the Division of Preventive Medicine. During the reorganization of 1970, the Division of Milk Control was assigned to the newly created Bureau of Environmental Health.

The following persons have headed the milk control program:

LeRoy R. Davenport, D.V.M., M.P.H.

Enos G. Huffer, B.S.

Harold E. McAvoy

Division of Preventive Medicine

In 1962, this division was made up of the Bureaus of Epidemiology, Hazardous Substances and Poison Control and Maternal and Child Health. In fiscal year 1963, the section on school health became a division, adding to its staff a hearing conservation coordinator in May, 1963, and a vision coordinator on September 1, 1963.

With the reorganization of 1970, all the programs of this division were transferred to the new Bureau of Personal and Community Health, and the Division of Preventive Medicine ceased to exist as an administrative entity. During its existence, it was headed by:

Donaldson F. Rawlings, M.D., M.P.H.

Norman J. Rose, M.D., M.P.H.

Serving as chiefs of the units within this division were the following:

Epidemiology

Norman J. Rose, M.D., M.P.H.

Richard H. Suhs, M.D.

Hazardous Substances and Poison Control

Norman J. Rose, M.D., M.P.H.

Maternal and Child Health

Donaldson F. Rawlings, M.D., M.P.H.

James P. Paulissen, M.D., M.P.H.

School Health

Donaldson R. Rawlings, M.D., M.P.H.

James P. Paulissen, M.D., M.P.H.

Division of Hospitals and Chronic Illness

This division was so named in 1961. On November 3, 1967, it was renamed the Division of Health Care Facilities and Chronic Illness, recognizing that facilities other than hospitals were involved in health care. In the reorganization of 1970, this division became the Bureau of Personal and Community Health, absorbing the functions previously assigned to the Bureau of Nursing in General Administration; the Division of Dental Health; and the Division of Preventive Medicine. The division also added a new program, to be known as Emergency Medical Services and Highway Safety. The programs related to health care facilities and chronic illness were retained. As constituted in 1970, the new bureau was made up of the Divisions of (1) Chronic Illness, (2) Disease Control (formerly Epidemiology), (3) Family Health (formerly Maternal and Child Health), (4) Health Facilities, (5) Nursing, and (6) Emergency Medical Services and Highway Safety.

The Division of Hospitals and Chronic Illness, becoming the Bureau of Personal and Community Health in 1970, was the responsibility of the following persons during the Yoder administration:

Roger F. Sondag, M.D., M.P.H.

Bruce Flashner, M.D.

Throughout the history of the department, an assistant director was seldom appointed: most directors had their own administrative officers and found little need or use for an assistant director. A notable exception to this was during the Fatherree administration when Doctor Sondag, appointed by Governor Stratton as assistant director, also became the chief administrative officer of the department. Doctor Flashner became the chief of the Bureau of Personal and Community Health, whereupon Doctor Yoder, in real need of a medical assistant, appointed Doctor Sondag to the position, which had been vacant since Doctor Press' resignation on September 20, 1967.

During the Yoder administration, the following served as chiefs of these units:

Health Facilities (formerly Hospitals)

George A. Lindsley, M.P.H.

Harold E. Josehart, M.S.H.A.

Paul X. Elbow, M.S.H.A.

Chronic Illness (formerly Geriatrics)

Roger F. Sondag, M.D., M.P.H.

William J. Cassel, M.D., M.P.H.

Clifton Hall, M.D., M.P.H.

Disease Control (formerly Epidemiology)

Norman J. Rose, M.D., M.P.H.

Richard H. Suhs, M.D.

Byron J. Francis, M.D.

Family Health (formerly Maternal and Child Health)

James P. Paulissen, M.D., M.P.H.

Dental Health

Carl Sebelius, D.D.S., M.P.H.

Nursing

Helen M. Bruening, R.N., M.P.H.

Emergency Medical Services and Highway Safety

David R. Boyd, M.D.C.M.

Since the above is the first reference to Emergency Medical Services and Highway Safety, some note should be taken of its beginnings as a new departmental activity. The Division of Disease Control contained a section on traffic safety that had been concerned with the blood-alcohol study and the Cornell traffic safety study. In early 1971, Governor Ogilvie sent to the department a young resident physician at Cook County Hospital, Doctor David R. Boyd, who laid claim to an innovative approach to emergency medical services. The idea impressed the governor, as it did the director; so, on March 10, 1971, the Division of Emergency Medical Services and Traffic Safety was established in the Bureau of Personal and Community Health. This program, along with Implied Consent, is treated later on as a special activity since it was so closely allied with the governor's office.

Division of Food and Dairies

For many years, health interests had advocated that the food and dairy industry be regulated and supervised by the Department of Public Health rather than the Department of Agriculture. Such a transfer was strongly opposed by the Department of Agriculture and by other agricultural interests in the state, which brought pressures to bear upon governors and general assemblies. Various governors refused to countenance the introduction of transfer legislation into the general assembly by the department. Finally, under Governor Kerner, the 74th General Assembly enacted Senate Bill 1170, and Senate Bills 1173 through 1178, transferring the administration of numerous food and dairy laws to the department and creating the Illinois Uniform Food Act, all of which were approved by the governor. On November 1, 1965, the new Division of Foods and Dairies was established in the department, and Doctor Press, medical assistant to the director, was named as acting chief.

On January 1, 1968, the director changed the division's name to the Division of Foods and Drugs to make a logical place for the drug sanitation responsibilities assigned to the department by the enactment of H.B. 775, which created a new Uniform Food, Drug and Cosmetic law.

Two persons have served as chiefs of this unit:

Edward G. Press, M.D., M.P.H., Acting
Roy W. Upham, D.V.M., M.P.H.

In 1970, this division came under the supervision of the Bureau of Environmental Health, reporting to Verdun Randolph, M.P.H., Bureau Chief, rather than directly to Doctor Yoder.

Division of Sanitary Engineering

In 1961, this division was made up of five Bureaus: (1) General Sanitation, (2) Public Water Supplies, (3) Stream Pollution, (4) Special Services, and (5) Radiological Health and Air Pollution Control. The ever increasing interest in, and attention to, radiological health and air pollution had so accelerated that, by July 1, 1966, it was found necessary to replace the Bureau of Radiological Health and Air Pollution Control with two bureaus—the Bureau of Radiological Health and the Bureau of Air Pollution.

This division had always been strong and was well known for its accomplishments. Nevertheless, on June 29, 1970, Governor Ogilvie approved H.B. 3788, known as the Environmental Protection Act,

thereby establishing three new agencies: (1) the Environmental Protection Agency, (2) the Pollution Control Board, and (3) the Institute for Environmental Quality. A companion series of bills, H.B. 3790 through H.B. 3827, were approved on June 29 and 30, 1970, that resulted in the demise of the State Sanitary Water Board, which had been in existence since 1929, and the transference of department responsibilities for air pollution control, water pollution control, and public water supplies to the new Environmental Protection Agency. The establishment of this new agency, concerned only with problems of pollution, was becoming a national trend. The transfer of the public water supply program, however, appeared to be incongruous since that activity was basically "health," rather than "pollution," in character. Doctor Yoder made strong and lengthy overtures to the governor's liaison to retain this activity, but his arguments and pleas fell on deaf ears. The loss of these important programs had a traumatic effect upon the department; and the process of separation–involving personnel, equipment, and supplies–became a source of frustration and irritation for a period of almost six months. In comparison with the appropriations to the new agency, the appropriations made to the department for these activities had been parsimonious.

Immediately following these changes, which saw the chief sanitary engineer of the department become the director of the Environmental Protection Agency, Doctor Yoder appointed Verdun Randolph, M.P.H., as chief state sanitary engineer. Randolph came to the department as a district sanitary engineer and had, for years, been the assistant state sanitary engineer.

On August 31, 1970, with the sweeping reorganization of the department, the Division of Sanitary Engineering became the Bureau of Environmental Health. The new bureau was comprised of the remaining Divisions of General Sanitation, Special Services, and Radiological Health, and to it was added the Divisions of Milk Control, Food and Drugs, and Swimming Pools and Recreation.

During the Yoder administration, the following persons served as head of the Division of Sanitary Engineering (later the Bureau of Environmental Health). These persons actually carried three titles: (1) chief of the unit, (2) chief sanitary engineer, and (3) the civil service title of state sanitary engineer:

Clarence W. Klassen, B.S.

Verdun Randolph, M.P.H.

From 1961 through the remainder of the Yoder administration, the following persons headed up the various units under the Division of Sanitary Engineering (the Bureau of Environmental Health in 1970):

Assistant Chief Sanitary Engineer

Verdun Randolph, M.P.H.

Public Water Supplies

William J. Downer, B.S.

William Honsa, B.S.

Stream Pollution

Richard S. Nelle, B.S., B.E.

D. B. Morton, B.S.

Special Services

Eugene S. Clark, B.S.

General Sanitation

H. A. Spafford, B.E.

Otto S. Hallden, B.S.

Marshall Gish, M.P.H., Acting

Hoyt Frederick, B.S., Acting

James Yallaly, B.S.

Radiological Health and Air Pollution Control

C. W. Klassen, B.S., Acting

Robert R. French, Ch. E.

Radiological Health

Verdun Randolph, M.P.H., Acting

Leroy E. Stratton, M.S.P.H.

Philip N. Brunner, M.S.

Air Pollution Control

Robert R. French, Ch. E.

Swimming Pools and Beach Sanitation

William Honsa, B.S.

Jerry Ackerman, B.S.

Foods and Drugs (listed previously)

Milk Control (listed previously)

To the reader not well acquainted with governmental operations, the turnover in executive personnel may seem somewhat excessive. It should be noted, however, that the great majority were well-qualified, in some cases over-qualified, for the positions they held.

qualified, in some cases over-qualified, for the positions they held. Some came to the department to gain experience; some were lured away by higher salaries. By and large, however, the department has maintained a dependable core of dedicated employees. Turnover has consistently been among the lowest among the code departments.

THE LASHOF ADMINISTRATION

On February 23, 1973, Governor Dan Walker appointed Joyce C. Lashof, M.D., of Chicago, the acting director of the Illinois Department of Public Health—the first woman to hold this position. At the time of her appointment, she was serving as chairman of the Department of Preventive Medicine at Rush–Presbyterian–St. Lukes Medical Center in Chicago.

Doctor Lashof was graduated from Duke University and Women's Medical College of Pennsylvania. In 1965, she co-authored a report on methods of providing comprehensive health care to the poverty-level population. In 1967, she assisted in the organization of the Mile Square Health Center, which served some 25,000 low-income residents on Chicago's West Side. On a special fellowship from the United States Public Health Service, she studied epidemiology and medical care at the Department of Social Medicine, University of Oxford, in England.

Doctor Lashof was necessarily appointed as acting director since she did not fully meet statutory requirements. As acting director, she was not subject to confirmation by the Illinois Senate.

Doctor Yoder resigned, but stayed on for a few months as a consultant.

Doctor Lashof carried the title of acting director until June 30, 1973, when the general assembly rescinded, for what was alleged to be a temporary period, that portion of the statute requiring a master's degree in public health, whereupon she became director by appointment and by confirmation of the senate.

Doctor Lashof exhibited a dynamic and affable personality toward those with whom her work brought her into close contact. She was probably one of the most astute of all directors in matters of the budget and financial affairs and was effectively articulate and knowledgeable in dealing with the general assembly.

Governor Walker, like his two predecessors, established a system of liaison intermediaries and appointed Miss Georgi Jones to the Department of Public Health. Miss Jones proved to be understanding, helpful, and cooperative in her work with the department. The director's relationship with the governor's office was excellent

throughout the four years. Doctor Lashof represented the department on the governor's health cabinet, which was made up of the directors of other health-orientated agencies, namely the Department of Mental Health, the Department of Public Aid, the Department of Children and Family Services, and the Office of Comprehensive Health Planning.

With the defeat of Governor Walker in his bid for a second term, Doctor Lashof resigned on February 8, 1977. Pending the appointment of a director by the new governor, Allen N. Koplin, M.D., M.P.H., was named acting director. Doctor Koplin served in this capacity from February 9 to March 1, 1977.

Organization and Personnel

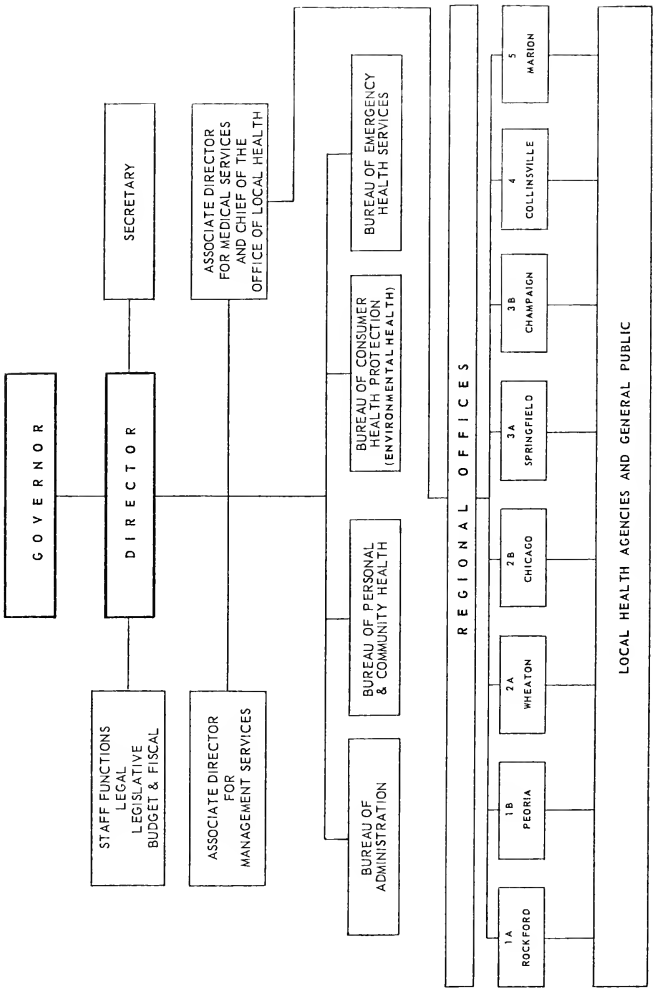
When Governor Walker came into office, the chief of the Bureau of Personal and Community Health (also the deputy director appointed by Governor Ogilvie) resigned. Doctor Lashof elected to supervise this function directly until a replacement could be found.

On August 16, 1973, Doctor Lashof reorganized the Department as shown on page 22. This reorganization proved to be of an interim nature.

The positions of assistant to the director and medical assistant to the director were abolished. In effect, they were replaced by an associate director for management services and an associate director for medical services, respectively. To the latter was also assigned the Office of Local Health Administration, thus placing the responsibility for local health administration at a higher level in the organization.

The associate director of medical services was assigned the responsibility for coordinating program activities between all bureaus, with special emphasis on the delivery of services at the regional level. Stephen H. King, M.D., was appointed to this position in August, 1973, and given the additional responsibility of acting for Doctor Lashof in her absence. Before coming to the department, Doctor King had been the director of the Northeast Health District of the Georgia Department of Human Resources.

To the position of associate director for management services was appointed Isabelle Crawford, M.A., who had been the chief of the Division of Electronic Data Processing under Doctor Yoder and who had left the department to subsequently become the supervisor of the Management Information Division, the centralized computer agency for the state. The associate director for management services was assigned responsibility for management and administrative policy throughout the department.



ORGANIZATION AS OF AUGUST 16, 1973

The other changes were relatively minor. The name of the Bureau of Environmental Health was changed to the Bureau of Consumer Health Protection, but with no change in responsibilities; Emergency Medical Services was changed to Emergency Health Services and was raised to bureau status; and the Bureau of Personal and Community Health, while maintaining the same responsibilities, obtained the services of Michael Werckle, M.D., as chief. Just before coming to the department, Doctor Werckle had been the director of the Long Term Care Facility, Wayne County General Hospital, and director of Medical Systems, Medical Data Systems Corporation.

On August 29, 1973, the Chicago offices of the department were consolidated at one location. The office of the director, the food and drug offices, and the regional office (formerly in the Chicago State Tuberculosis Sanitarium) were relocated to the eleventh floor of the State of Illinois Building at 160 North LaSalle Street in Chicago. Office space at that location was subsequently made for Doctor Mark Lepper, who had been named state coordinator of health.

Other minor changes took place at this time: the blood bank licensure program was removed from Emergency Health Services and transferred to the Bureau of Personal and Community Health; the Division of Nursing was transferred from the Bureau of Personal and Community Health to the Office of the Associate Director for Medical Services; and the legislative and legal staff, as well as the budget and fiscal officer, became part of the director's office.

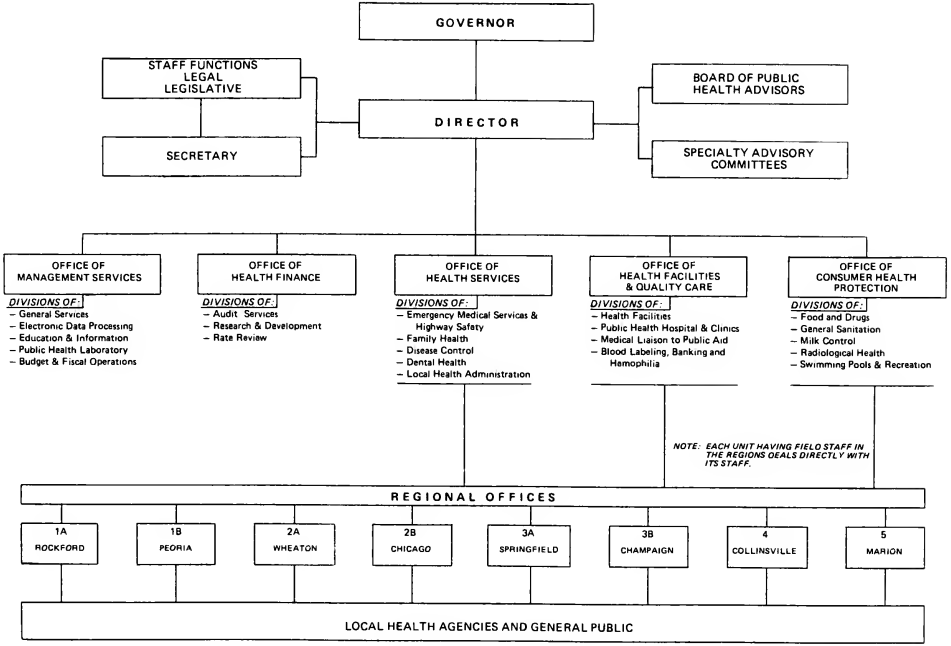
At the time, Doctor Lashof was quoted as saying "further organizational changes will be undertaken when indicated."

This change was not long in coming. On December 14, 1973, a directive was issued, revising the department organizational structure effective January 1, 1974. The directive abolished the term *bureau*, referring to their functions through the title of the person heading up the unit, such as "Associate Director for Health Facilities," etc. The organizational chart, adopted on January 1, 1974, is shown on page 24.

Thus, there were five major units, each headed by an associate director: (1) Management Services, (2) Health Finance (a new function), (3) Health Services, (4) Health Facilities and Quality of Care, and (5) Consumer Health Protection (formerly Environmental Health).

Management Services

This was the designation given to the previous Bureau of General Administration. Included within it were the Divisions of (1) Audits (a departmental function elevated to division status in 1975), (2)



ORGANIZATIONS AS OF JANUARY 1, 1974

Budget and Fiscal Operations (formerly called Accounting and Finance); (3) Education and Information, (4) Electronic Data Processing, (5) Public Health Laboratories, and (6) Vital Records (re-established as a division after a short period as a section in the Division of Education and Information). A seventh function was maintained and called the General Services Unit.

Persons who served as heads of these units during the Lashof administration are as follows:

Audits
Walter E. DeWeese (May 1, 1975–Present)
Budget and Fiscal Operations
Walter E. DeWeese (September 23, 1969–May 1, 1975)
George Akehurst (May 1, 1975–Present)
Education and Information
Stanley R. Miles, M.P.H. (August 1971–Present)
Electronic Data Processing
Thomas Stuckey (May 1, 1971–Present)
Public Health Laboratories
Richard A. Morrissey, M.P.H. (October 30, 1967–July 1, 1977)
Vital Records (Deputy State Registrar)
Stanley R. Miles, M.P.H. (February 1, 1974–April 30, 1976)
Aaron Vangeison (May 1, 1976–Present)
General Services Unit
Joseph Schweska (March 1, 1969–Present)

Late in the Lashof administration, Isabelle Crawford, the associate director for management services, retired due to ill health, and James H. Thayer was named as acting associate director. He had formerly served as executive assistant in the Division of Public Health Laboratories in Chicago.

Health Finance

Early in the Lashof years, this function was delegated to the department by Governor Walker, who also named Lowell Johnson as its associate director. This unit was made up of three divisions in the January 1, 1974 organizational structure—the Divisions of Audit Services, Research and Development, and Rate Review. However, in the subsequent pattern, these were reduced to two divisions—Hospital Audits and Research and Development. With the change of administration, Lowell Johnson resigned, and Thomas J. Walsh, Ph.D., became the acting associate director for health finance.

The following persons have served as the head of these units:

Hospital Audit
James H. Handy
Research and Development
Thomas Walsh, Ph.D.

Health Services and Local Health Administration

This unit actually represents a portion of the previous Bureau of Personal and Community Health, retaining the Divisions of Dental Health, Disease Control, and Family Health, while the Divisions of Local Health Administration and Emergency Medical Services were added. The Division of Nursing was abolished. The associate director for health services had resigned in May, 1974, whereupon Shirley Reed, M.S.P.H., took over the direct operation under Doctor Lashof on a temporary basis. On April 1, 1975, Allen N. Koplin, M.D., M.P.H., was employed as associate director for this unit.

Relative to the divisions in this major unit, the following persons served as division chiefs:

Disease Control
Byron J. Francis, M.D., M.P.H.
Emergency Medical Services
David Boyd, M.D.C.M.
Mohammad Akhter, M.B.B.S.
Dental Health
Carl Sebelius, D.D.S., M.P.H.
Bruce Douglas, D.D.S.
Family Health
James P. Paulissen, M.D., M.P.H.
Patricia Hunt, M.D.

Health Facilities and Quality of Care

This unit, like health services, was a part of the former Bureau of Personal and Community Health. It was made up of the Divisions of (1) Geriatrics and Long-Term Care; (2) Hospital, Laboratories, and Acute Care; (3) Development and Construction; (4) Planning and Conformance; (5) Ambulatory Care Review; and (6) Curriculum Development (not shown on the chart as a division). Doctor Michael Werckle was the associate director for this unit until his resignation on February 28, 1977. He was replaced by Patricia Nolan, M.D., who was appointed as acting associate director.

These divisions represented a whole new array in terms of titles and functions and are not readily traceable to previous units. The persons heading up these divisions were—

Geriatrics and Long-Term Care Programs
William Irvine
Hospital, Laboratories and Acute Care
Michael Grobsmith
Development and Construction (Hill-Burton)
Aden Clump, M.A.
Planning and Conformance
George A. Lindsley, M.P.H.
Ambulatory Care Review
Mary Beck, M.P.H.
Curriculum Development
Beth Walston

Consumer Health Protection

Aside from its change of name from Environmental Health to Consumer Health Protection, this unit experienced little change resulting from the reorganizations. It retained its previous five divisions and added one, the Division of Nuclear Safety. The six divisions that made up Consumer Health Protection were (1) Food and Drugs, (2) General Sanitation, (3) Milk Control, (4) Radiological Health, (5) Swimming Pools and Recreation, and (6) Nuclear Safety. On July 31, 1976, Verdun Randolph, M.P.H., retired as associate director and was replaced by Leroy Stratton, M.S.P.H., who had been the assistant chief sanitary engineer and assistant associate director.

Persons who headed up the divisions were—

Food and Drugs
Roy Upham, D.V.M., M.P.H.
General Sanitation
Robert Wheatley, B.S.
Milk Control
Harold E. McAvoy
Radiological Health
Philip Brunner, B.S.
Swimming Pools and Recreation
Jerry Ackerman, B.S.
Nuclear Safety
Gary Wright, B.S.

THE PETERSON ADMINISTRATION

On March 1, 1977, the new Governor of Illinois, James Thompson, named Paul Q. Peterson, M.D., M.P.H., as director of public health. Doctor Peterson, a native of Illinois, received his medical degree from the University of Illinois and his Master of Public Health (M.P.H.) degree from the University of Michigan. During more than thirty years of experience in public health and government service, he served as U.S. Deputy Surgeon General; deputy director of the Bureau of Public Health Services; assistant director of the National Institute of Allergy and Infectious Disease; and chief of the U.S. Chronic Disease Program. In 1971, the University of Illinois convinced Doctor Peterson to leave the U.S. Public Health Service to establish the school of public health. He was the dean of that institution when he accepted the directorship.

Among his numerous professional qualifications were a Diplomate of the American Board of Preventive Medicine; a Fellow of the American Public Health Association; and a member of the American Medical Association, the Association for the Advancement of Science, the Association of Military Surgeons, and the Association of Public Health Physicians.

At the age of sixty-four, Dr. Peterson became the twenty-first person to head up the Illinois public health service in its 100-year history as a board of health and as a department.

Governor Thompson's selection of Doctor Peterson was favorably received by health agencies, health workers, and educators. In addition to his distinguished career of accomplishment in public health and his eminent qualifications, he brought to the department an energetic confidence and a gracious attitude. The staff was not long in recognizing these attributes: his leadership generated enthusiasm and loyalty within and without the department.

The State Constitution had been rewritten some time prior to Doctor Peterson's appointment to provide for a two-year governorship from 1977 to 1979 in order to thereafter stagger presidential and gubernatorial elections. The theory motivating this action was to prevent the candidate for governor from riding to victory on the "coattail" of the presidential candidate.

This situation, unique in the history of the state, was thought by many to weaken the Governor's effort in recruiting capable and qualified department heads. In the case of the Department of Public Health, at least, this reasoning proved to be fallacious. From 1917, the director of public health had always served a formal and

statutory term of two years, or until his successor was appointed. It has always been obvious that a term of two years is too limited to produce significant results in government service. This is especially true in the area of public health.

For a number of years, advocates of continuity in the directorship had been discussing the re-establishment by statute of a duly constituted board of health. Presumably, a qualified, professional board of health would recognize ability and merit in a director, thus contributing to greater longevity in the directorship. This reasoning becomes even more plausible in an era when the practicing physician is generally highly successful monetarily. To be the director of public health calls for academic and field training beyond the requirements for practicing medicine and provides a comparatively modest level of remuneration and insecurity of tenure.

After seven months in office, Doctor Peterson addressed a joint meeting of the Illinois Association of Boards of Health and the Illinois Association of Local Health Administrators outlining the principles, policies, and priorities his administration would embrace.

The first priority announced related to the availability of the services of a "well-organized local health department to every person in Illinois." To this end, the director pledged support for (1) updated legislation that would allow for the establishment of local health departments; (2) increased financial assistance by the state to local health departments, the distribution of which would be based on population, program performance, and economic need; and (3) closer working relationships with local health departments through the strengthening of regional office staffs. He stressed the importance of health planning and active participation therein by local health departments.

Other priorities dealt with public health program initiatives: (1) occupational and industrial health; (2) monitoring of the toxicity of the environment; (3) development of housing standards to improve health conditions, possibilities for home health care, energy conservation, etc.; (4) development of multi-institutional systems between health care facilities to promote cost effectiveness, cost containment, and quality of care; (5) greater emphasis on preventable chronic disease and accidents; (6) revision of the organizational arrangement so as to emphasize ambulatory and primary care; and (7) a new and enlarged organization for health affairs in Illinois.

Some of these were innovative; others were unrealized department goals for many years. The announced priorities gave promise of a discerning and energetic administration.

Organization and Personnel

During the first ten months of the Peterson administration, no major changes were made either in the organizational structure of the department or in its personnel.

There were, however, a few changes worthy of note. The name of the Office for Consumer Health Protection was changed to the Office of Environmental Health. Within the office, the Division of Swimming Pools and Recreation was renamed the Division of Engineering and was assigned responsibility for the private water-well pump program, the private sewage contractors licensing program, the plumbers licensing program, the mobile home safety program, and the modular housing program. The programs for recreational areas and youth camps were transferred to the Division of General Sanitation, from which the others had come.

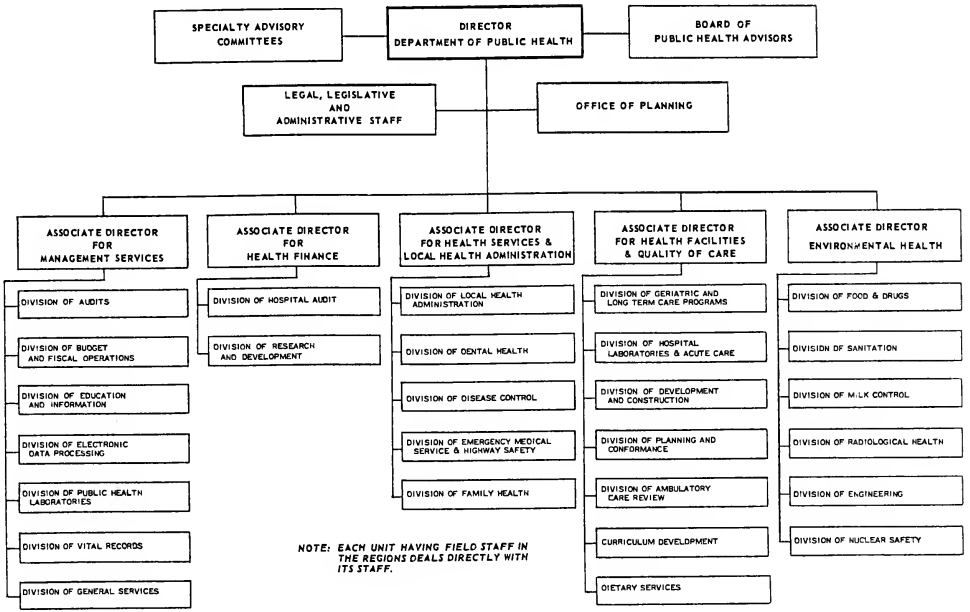
In the Office of Management Services, the general services unit was given divisional status, and Joseph Schweska, who headed the unit for many years, was made the division chief.

The chief of the Division of Laboratories, Richard A. Morrissey, M.P.H., retired in the summer of 1977.

In the Division of Dental Health, the resignation of Bruce Douglas, D.D.S., resulted in the appointment of William Babeaux, D.D.S., as chief.

The organization of the department in December of 1977 is shown on page 31.

ILLINOIS DEPARTMENT OF PUBLIC HEALTH



NOTE: EACH UNIT HAVING FIELD STAFF IN THE REGIONS DEALS DIRECTLY WITH ITS STAFF.

ORGANIZATION AS OF DECEMBER 1977

Chapter 2

ENVIRONMENTAL HEALTH

A Brief History

Over the period covered by this volume, one of the major units in the department has been variously known as the Division of Sanitary Engineering, the Bureau of Environmental Health, the Office of Consumer Health Protection, and the Office of Environmental Health.

When Doctor Yoder became director, the Division of Sanitary Engineering was responsible for all of the major environmental programs assigned to the department with the exception of the milk control program. The division itself was composed of five bureaus (see Organization Chart, page 7): (1) General Sanitation, (2) Public Water Supplies, (3) Stream Pollution, (4) Radiological Health and Air Pollution Control, and (5) Special Services. With the reorganization of 1970 and for the remainder of the Yoder administration, this major unit became the Bureau of Environmental Health, within which were the Divisions of General Sanitation, Milk Control, Radiological Health, Food and Drugs, and Swimming Pools and Recreation. During the Lashof administration, the Bureau of Environmental Health became the Office of Consumer Health Protection, and the sixth division, Nuclear Safety, was added.

Each of the subunits named above was vested with responsibilities of a related nature, and the programs and services within each are herewith described.

General Sanitation

This unit may be designated as the "catchall" for environmental programs and responsibilities not relating precisely to the other environmental units. This designation implies no derogation whatsoever, as the programs administered have been very important in the public health service of the state.

Migrant Labor Camp Law—This law became effective on January 1, 1961, and was passed to assure safe and sanitary housing for migrant laborers through inspection and licensing of migrant labor camps containing ten or more workers or four or more families. Originally, there were approximately 500 migrant labor camps licensed by the department. Over the years, the number of licensed migrant labor camps has declined to approximately ninety, due to various factors such as subdivision of land, mechanization, and conversion from vegetable and fruit crops to grain crops.

The department inspectional program consisted of prelicensure inspection and at least two inspections while the camp was occupied by migrant laborers. In 1974, emphasis was placed on greater delivery of services to migrants and the Illinois farmer by expanding the program to include three operational inspections and a post-season inspection of each migrant labor camp. In addition, the department entered into a cooperative agreement with the Illinois Department of Labor to evaluate the migrant labor camps for compliance with federal standards and, subsequently, the filling of work orders filed by the Illinois farmer with the Department of Labor.

Under this agreement, department personnel check on the licensure status of farm laborer contractors and obtain copies of the "Term and Conditions of Employment Agreement" filed by the farmer with the Department of Labor. Department personnel complete a form containing questions pertinent to the Department of Agriculture in providing better services to the Illinois farmer and provide public aid information to migrant workers and their families in cooperation with the Department of Public Aid. The Department of Public Health continues to monitor nonlicensable migrant labor camps for major health problems associated with water, sewage disposal, refuse collection, and insect and vector control. These expanded duties increased the department's personnel from three to seven with the last four personnel being fluent in both Spanish and English.

The migrant labor camp program has, since its inception, been subject to criticism both by Illinois truck farmers and by groups interested in the welfare of migrants, with the department caught in the middle. The welfare groups consistently and continually demand more and better treatment of the migrants, while farm groups constantly complain of expenses therefor.

Private Water Supply Program—This program came into formal existence with the passage in 1965 of the Water-Well Construction Code (S.B.640) and the Water-Well Pump Installation Code (S.B.645). Prior to the recognition of this need by the General Assembly, the

department had, on an elective basis, inspected and tested private water supplies when so requested or when an illness occurred that had the characteristics of being waterborne.

These two laws and adopted rules provided the construction and installation requirements essential for developing a safe, private water supply. The rules and regulations were revised and updated in 1970, 1973, and 1977 to keep abreast of the latest developments in water-well technology.

Since the law became effective, approximately 10,000 new wells have been developed each year by some 680 licensed well drillers and pump installers. Regional personnel inspect the construction of approximately 20 percent of all new wells developed and evaluate the performance of licensed contractors on an average of at least three times per year. Violations of the two codes are brought to the attention of the contractor for immediate, voluntary correction. Failure of the contractor to make the necessary corrections for bringing the well into compliance with the department's codes results in referral to the Department of Registration and Education for litigation against the contractor's license. Regional personnel also evaluate over 20,000 private water-well samples submitted by individuals to the department's laboratory and provide consultation to home owners for the correction of contaminated or unsafe water supplies. The initial program began with one program administrator in 1968 and, in 1977, employed ten field sanitarians in seven regional offices.

Approximately two million Illinois citizens currently obtain their drinking water from private water supplies, the wells for which must be properly constructed and maintained to assure water that is free from bacterial and chemical contamination.

For enforcement of these laws $270,000 was first appropriated. Approximately $135,000 has been appropriated for annual support of the program since 1965. Credit for the passage of these bills, which are the only ones insuring water safety to suburban and rural dwellers, goes to the trade association involved. The department assumed responsibility for the licensure of water-well contractors and pump installers in 1971.

Private Sewage Disposal Program—This program had, for almost sixty years, been carried on by the department, providing technical assistance and consultation relative to the disposal of human wastes by methods other than the use of municipal sewage disposal systems.

In 1974, the Private Sewage Disposal Licensing Act was enacted and rules and regulations promulgated by the department. This law

required that all private sewage disposal contractors be licensed by the department and perform their work in accordance with the standards established for the design, construction, materials, operation, and maintenance of private sewerage systems and the transportation and disposal of waste removed from such systems. Local health departments administering a private sewage disposal ordinance had to be in compliance with the minimum standards established by the department, and their ordinances and performance standards had to be approved by the department.

The program was initiated with one person employed to serve as program administrator in 1974. In 1977, an additional seven field sanitarians were employed to conduct inspections of new systems installed by licensed contractors and to respond to complaints of malfunctioning systems reported to the department.

Here again, the legislation establishing this program was supported wholeheartedly by the manufacturers of septic tanks.

Illinois Trailer Coach Park Control Law—Enacted in 1953, this law was repealed and replaced by a new law (S.B.198) that became effective April 30, 1972, and was known as the *Mobile Home Parks Law*. Also enacted at that time was the law regulating travel trailer parks. The new law, like the old, provided for the licensing and regulation of mobile homes and mobile home parks as they related to mobile home park construction and operation. The new law recognized the changes made by the industry in the construction of mobile homes and the technology in land development, while maintaining the environmental factors essential to mobile home dwellers such as drainage, site development, water supply, sewage disposal, refuse collection, storage and disposal, roadway construction, and electrical and fire safety standards.

The Department of Public Health employed regional personnel responsible for conducting annual inspections of over 1,000 mobile home parks subject to the department's jurisdiction. Four hundred additional mobile home parks are not inspected by the department's staff since these mobile home parks are located within Home Rule units of the state or are exempted by statutory definition of a mobile home park. Of the mobile home parks inspected by the department, 80 percent have been found to be in compliance with the law and adopted rules and regulations on the first inspection each year. Operational inspections, in addition to annual inspections, have been conducted in the other 20 percent of the mobile home parks in an effort to upgrade them to 100 percent compliance with the Mobile Home Parks Law and rules and regulations.

Illinois Mobile Home Safety Act—In effect, this act was an

outgrowth of the trailer coach park control program. The major purpose of this act, beginning in 1974, was to protect the housing aspects of mobile home dwellers. Assigned to the department, and delegated to the Division of General Sanitation, was the responsibility for regulating the structural stability, plumbing, mechanical, and electrical features of mobile homes. As a result, plan review and approval, certificates of compliance, and evidence of state seals became a necessity for every mobile home offered for sale or resale in the state of Illinois by every in-state and out-of-state manufacturer doing business in Illinois. In 1976, the Illinois Mobile Home Safety program was approved by the U.S. Housing and Urban Development Department to implement the 1974 Federal Housing and Community Development Act, Title VI.

The division's authority to regulate the housing environment was expanded to include manufactured or modular housing in 1976. The regulatory responsibilities of this program are equivalent to the Illinois Mobile Home Safety program with approximately fifty manufacturers of modular homes being regulated by the department.

Under the combined programs, the division regulates over 25 percent of the total housing available to Illinois residents.

Plumbing Code Law—Enacted in 1959, the Plumbing Code Law authorized the department to develop and promulgate a plumbing code and to assist units of local government with the establishment and the administration of a plumbing program by local ordinance.

The Plumbing Contractors Certification Act, enacted in 1967, provided authority to the department to certify approximately 2,500 plumbing contractors doing business in Illinois and appropriated $292,174 therefor. Each plumbing contractor was required to be a licensed plumber, employ registered plumbers and apprentice plumbers when engaged in the installation of plumbing, and furnish evidence of a $20,000 performance bond. Plumbing contractors and their employees were required to install plumbing in accordance with the plumbing code established by the department until September, 1971, when the law was declared unconstitutional. Because of the cross connections and faulty plumbing identified during the four-year period (1967–1971), the Plumbing Code Law, as established in 1959, was amended to require that all plumbers and apprentice plumbers comply with the department's plumbing code.

In 1973, authority for the administration of the Plumbing License Law was transferred from the Department of Registration and Education to the Department of Public Health. The transfer of this law unified the plumbing program in Illinois and the public health protection measures provided by the department.

The department employed, in 1977, one program administrator and twelve licensed plumbing inspectors who performed over 7,500 plumbing code inspections annually and provided consultation to units of local government and private citizens on principles of plumbing and methods of installation.

Uniform Hazardous Substances Act—This act, effective in 1960, required precautionary labeling of certain hazardous household chemical products. In 1972, the act was amended to include toys and other children's articles that presented electrical, mechanical, or thermal hazards and authorized the department to ban such dangerous substances. At that time, the program was transferred to the Division of Sanitation and an administrator was hired. The Poison Prevention Packaging Act, the Lead Poisoning Prevention Act, and the Lens and Frame Act were enacted after 1972 and enhanced the possibilities for reducing consumer exposure to hazardous or toxic products. Seven additional personnel were added to the program in the regional offices to perform inspections of manufacturers, distributors, and retailers of these substances.

In 1974, the department successfully negotiated the first of three subsequent contracts with the U.S. Consumer Products Safety Commission. In addition, regional personnel were called upon to respond to consumer complaints regarding potentially hazardous products and have been involved in several major recalls of products posing substantial risk of injury or illness to the consumer. Some of the nationwide recalls included spray adhesives causing potential chromosomal damage; imported yarns infested with anthrax bacteria; automotive trouble lights with exposed electrical wiring; and Christmas tree lights with electrical and fire hazard potentials. Through public awareness, injury surveillance, accidental poisonings reported to the division, and routine inspections, a safety conscious attitude developed among Illinois manufacturers and retailers to prevent or remove harmful products from the retail market.

Pesticide and Vector Control Program—For many years the department carried on a pesticide and vector control program on an elective (nonstatutory) basis. This entailed consultation, field surveys and identification of insects and household pests for private citizens and units of local government. The department, through its entomologist, acted as consultant to the various mosquito abatement districts in the state.

As the hazards of pesticides became more fully recognized, a voluntary Interagency Committee on Pesticides was formed in fiscal year 1964, made up of representatives from the Departments of

Public Health, Transportation, Agriculture, and Conservation, as well as the Illinois Natural History Survey and the University of Illinois.

The 74th General Assembly enacted and Governor Kerner approved H.B. 1513, which officially created an Interagency Committee on Pesticides to study and to advise on the use of pesticides. Following the recommendations of the committee, the General Assembly passed the Pesticides Control Act, which the governor approved on June 25, 1969. This law empowered the directors of Public Health and Agriculture "to propose and enforce regulations concerning the labeling, sale, use or application of pesticides." Under this law, the Department of Public Health established rules and regulations prohibiting the use of sodium fluoroacetate, fluoroacetamide, and DDT, except by permit, to insure that these pesticides are used properly without potential detrimental effects to the environment. These rules were reviewed by other members of the Interagency Committee on Pesticides. No permits have been issued by the department for DDT due to the current ban on its sale and use, and only a limited number of permits have been issued semiannually for the use of sodium fluoroacetate and fluoroacetamide.

Illinois Structural Pest Control Act—Enacted in 1975, this act provides for the licensure of all Illinois pest control businesses and for the certification of structural pest control technicians employed by Illinois pest control businesses.

During the brief history of this program, ten examinations in five different categories of structural pest control have been administered to over 1,200 structural pest control technicians. A training program precedes each examination and includes training on pesticide labeling, the environment, types of pesticides, pesticide equipment, and pesticide laws and regulations. Categories of the examination include general insect and rodent control, termite and other wood-destroying organisms, and food processing and manufacturing pest control.

Institutional Sanitation Program—This program was established to provide consultation and inspection of facilities owned, operated, or regulated by the Department of Public Health or other state agencies, for environmental and sanitary conditions, that would adversely affect the health of residents of those facilities.

After an interruption of such services from 1967 to 1971, the division developed an ongoing inspectional program for 270 hospitals licensed by the Department of Public Health. Program staff consisted of one program administrator and two regional personnel. All hospitals were inspected at two-year intervals and more than thirty

children's institutions were inspected annually. In 1972, environmental sanitarians of the department conducted inspections of ten adult correctional centers, ten juvenile correctional centers, and 101 county jails for the Department of Corrections. Inspections of children's institutions, penal institutions, schools, nursing homes, alcoholic treatment centers, mental health institutions, and day care centers are conducted upon request depending upon availability of personnel and the concerns of the agency regarding the sanitary conditions of the facility.

Milk Control

The milk control program is responsible for enforcement of the state milk and dairy product laws and the authorized rules and regulations. It is responsible for assuring the public that the milk and dairy products they consume are safe, wholesome, and nutritious.

During the first half of the 1900s, many milk-borne epidemics were reported throughout the nation causing illness and many deaths from typhoid fever, paratyphoid fever, scarlet fever, septic sore throat, diphtheria, staphylococcus food poisoning, and many other diseases that had been transmitted from the use of raw milk and from improperly pasteurized milk.

In 1945, the General Assembly passed the Grade A Pasteurized Milk and Milk Products Rules and Regulations. In 1955 the legislature made this law compulsory and also passed a law that required all fluid milk and milk products sold in the state of Illinois to be pasteurized and to carry the Grade A label. This program did not cover manufactured products such as ice cream, cheese, butter, evaporated milk, dry milk, and condensed milk. These products were under the jurisdiction of the Illinois Department of Agriculture. In 1964, the General Assembly transferred this program from the Department of Agriculture to the Department of Public Health, giving the Department of Public Health jurisdiction over all milk and dairy products in the state of Illinois. These manufactured milk products were controlled under the Pure Food Law although the requirements for production, processing, and handling were very vague. In 1967, the legislature passed the Food, Drug, and Cosmetic Act, which became effective January 1, 1968. This gave the director of the department the power to promulgate new rules and regulations to control milk and dairy products. New rules and regulations were promulgated for manufactured milk products and became effective in March of 1969. These rules and regulations were updated in 1972

to conform with federal recommended standards for manufactured milk and milk products.

In 1964, the Bulk Milk Tank Operators Licensing Act was passed, requiring all bulk milk tank operators who pick up milk at the farm and transport it to the processing plants to be licensed by the state of Illinois and to follow rules and regulations for the grading, sampling, and collection of the raw milk at the farm. These operators must pass an examination before licenses are issued. Licenses are issued on an annual basis. Routine inspections are made of these operators to assure full compliance with the rules and regulations for the collection and transportation of raw milk to the processing plants.

Illinois adopted the 1965 recommendations of the U.S. Public Health Service Grade A Pasteurized Milk Ordinance permitting the movement of milk and dairy products in interstate commerce on a reciprocity basis.

Illinois, in 1977, had one of the most up-to-date and complete set of laws, rules and regualtions for the production, handling, processing, packaging, labeling, and distribution of milk and dairy products in the nation. These laws were rigidly enforced through routine unannounced inspections from the time the milk is taken from the cow until it reaches the consumer. This included the sampling of both raw milk and all finished products. Information on the health of the producing animals was supplied to this department by the Illinois Department of Agriculture, Division of Animal Industry.

In 1972, Illinois began a statewide testing program for pesticide levels in raw milk. This program was very effective and only traces, well below the acceptable level, were found in a few supplies.

Food and Drugs

As the result of legislation (H.B.1173 through 1178), enacted by the 74th General Assembly, the Division of Foods and Dairies was transferred from the Department of Agriculture to the Department of Public Health on November 1, 1965. Retained, however, by the Department of Agriculture, were responsibilities for the inspection of meat and poultry at other than retail outlets, egg grading, handling, and processing; and licensing of cold storage warehouses, locker plants, and salvage warehouses.

Also in 1965, the Illinois Uniform Food Act (H.B.1170), was enacted, which provided that food sold at the retail level be supervised by the department. Also enacted in 1965 was an amendment (S.B.1180) to the Sanitary Inspection Act of 1911, whereby the department became responsible for food at the retail level.

Retail Food Sanitation Program—Evolving from this legislation was the retail food sanitation program designed to assure the wholesomeness of food purchased in a public eating place or in a retail market. To carry out this responsibility, the division activities included conducting sanitary inspections of establishments; training and certifying of food establishment managers; assisting local health department inspectors in improving their inspectional techniques; evaluating and standardizing inspections; conducting surveys; providing inspection, embargo, and voluntary destruction of food involved in fires, floods, truck and train wrecks, and other disasters; and consulting with the food industry.

On January 1, 1968, the Illinois Food, Drug, and Cosmetic Act (H.B.775) became effective. The director then changed the name of the Division of Foods and Dairies to the Division of Food and Drugs. The additional responsibility involved was primarily for the control of prescription and over-the-counter drugs, devices, and cosmetics. Narcotics and similarly dangerous drugs remained with the Division of Narcotics of the Department of Public Safety.

Food Processing Program—The food processing program was begun with enactment of the Illinois Food, Drug, and Cosmetic Act. The act was designed to assure that processed and manufactured foods are pure and wholesome, legibly and truthfully labeled, and not adulterated or misbranded. Activities include the inspection of food processing plants, sampling of raw materials and processed foods, and embargo of suspect foods.

Starting with one inspector–administrator who coordinated both the food processing and drug processing programs in 1969, the drugs, devices, and cosmetics program required inspectional time to assure that drugs were safe and efficacious, were truthfully labeled, and met purity standards.

The Division of Food and Drugs laboratory was transferred to the Division of Laboratories in 1970. The various programs of this division dealing with food service establishments and food processors involved more than 50,000 establishments. The number of inspectors, however, was substantially below acceptable national standards. Records indicated that an inspection every three years or longer was the extent of supervision that could be given.

Swimming Pools and Recreation Areas

Swimming pools and bathing beaches have been regulated in Illinois by the department since 1931. The first public swimming pool law was enacted on July 8, 1931, and the first set of rules and

regulations were promulgated July 15, 1935. Prior to 1970, the swimming pool program was conducted by a section in the Bureau of Public Water Supplies. When the latter program was transferred that year to the Environmental Protection Agency, the swimming pool program was elevated to division status in the new Bureau of Environmental Health.

Recreational Area Licensing Act—This act, which became effective January 1, 1972, assigned to the department the responsibility for the regulation and licensing of recreational areas. This function was placed in the Division of Swimming Pools and the word *Recreation* added to its title. Also effective on January 1, 1972, was the Youth Camp Health and Safety Act. Under the act, all youth camps were required to be inspected and licensed.

On January 1, 1974, the swimming pool law was repealed and a new Swimming Pool and Bathing Beach Act became effective. Although pools and beaches had been inspected under the old law, they were not routinely inspected and licensed until enactment of the new law. The following activities are included under this law:

1. Plans and specifications for proposed new construction receive a thorough engineering review to determine compliance with design standards.
2. Construction permits are issued for approved plans for new pools and for alterations to existing pools.
3. Pool construction is crosschecked by regional engineers to insure that approved plans are followed.
4. Engineering studies are completed on all pools and formal engineering reports are sent to pool owners giving approval or making recommendations for correction of deficiencies.
5. Pool operation is observed by engineers and sanitarians, and samples are collected for chemical and bacterial analysis in the laboratory.
6. Field chemical tests are performed during pool inspection.
7. Daily operational reports are received monthly for review and study.
8. Laboratory results are interpreted by the engineering staff and results are mailed to pool owners and operators.
9. One-day training programs for pool operators are conducted annually in eight separate locations by the engineering staff. Pool operators are given instruction about proper pool operation, chemical and bacterial control of pool water, operation and maintenance of mechanical and electrical equipment, and other related items.

Staff of the public swimming pool program meet with consulting engineers, municipal and park district officials, and others to aid in developing pool designs and to insure safe and efficient pool operation. Staff is required to exercise judicious use of authority to close pools for cause, to hold formal hearings, and to bring violators to trial.

Recreational Area Licensing Act—With the passage of this law, the need for better sanitation in recreational areas was officially recognized. The responsibility for the public health aspects of these areas was placed in the department. The program includes the following:

1. Plans and specifications for new construction receive a thorough engineering review, and permits are issued for all new construction.
2. Plans and specifications for modifications, alterations, and improvements receive an engineering review, and permits are issued as defined by law.
3. All recreational areas are licensed annually to assure compliance with regulations on health and safety.
4. Construction of new facilities and modifications covered by permits are checked by field personnel to assure conformance with minimum standards.
5. Field inspections of all facilities are performed to assure proper operation and compliance with regulations. This includes sample collection for bacterial analysis of public water supplies, bathing beaches, and food service.

The staff provides technical assistance to owners and operators of recreational areas to help them assure the public a safe, sanitary facility for its use and enjoyment. Where necessary, enforcement action may be taken.

Youth Camp Program—The youth camp program regulates approximately 300 youth camps in the state. The program provides for the following:

1. Operational permits are issued annually to all youth camps to assure compliance with regulations and standards.
2. Inspections are made of all facilities for such things as water supply, sewage disposal, food handling, etc., which affect health and safety at youth camps.

The youth camp program is intended to provide a service to the public by assuring camps that are safe and sanitary for the children who use them. In addition, a service is provided to the camp operator

in the form of professional assistance in solving technical problems related to health and safety.

On April 1, 1977, the new director of the department, Doctor Paul Q. Peterson, changed the name of the Office of Consumer Health Protection to the Office of Environmental Health (its previous name) and the Division of Swimming Pools and Recreation to the Division of Engineering. The administration of the recreational area and youth camp programs was transferred to the Division of Sanitation, while the newly-named Division of Engineering was given the responsibility for (1) the swimming pool and bathing beach program, (2) the private water-well pump program, (3) the private sewage contractors licensing program, (4) the plumbers' licensing program, (5) the mobile home safety program, and (6) the modular housing program. (A description of the last five was given previously under "General Sanitation".)

Radiological Health

In 1961, this unit was known as the Bureau of Radiological Health and Air Pollution Control. These two functions were subsequently separated on July 1, 1967, into two bureaus. The history of the air pollution control program will be documented later.

In 1955, the General Assembly created the Atomic Power Investigating Commission to pursue the investigation and study of the economic and social impact of peaceful uses of atomic energy. In 1956, the department began the air surveillance program in cooperation with the U.S. Public Health Service National Air Surveillance Program. From 1957 to 1959, after passage of the Radiation Installation Registration Law in 1957, a representative group of users of various types of radiation machines and radioactive materials were inspected and the findings reported to the Legislative Commission on Atomic Energy (successor to the Atomic Power Investigating Commission). Based on these findings, the Radiation Protection Act, requiring regulation by the department of all radiation sources, was enacted in 1959. The department also began its nuclear power surveillance activities prior to the operation of the Dresden reactor in the early 1960s. These activities included the sampling of surface waters, ground waters, milk supplies, air for particulate matter, and the wildlife. This activity also included analyses and tabulation of data received from other agencies and from power utilities as well as from the Argonne National Laboratory.

During fiscal year 1965, the Illinois General Assembly passed,

and the governor approved, seven significant laws relating to radiological health with major responsibility given to the department:

1. S.B.756, requiring the registration, licensing, inspection and control of radiation sources; establishing a technical advisory council; and authorizing the governor to enter into certain agreements with the United States government.
2. S.F.757, providing that the Department of Public Health may license and control radiation sources.
3. S.B.832, creating the Illinois Legislative Commission on Atomic Energy and appropriating $5,000 therefor.
4. S.B.833, authorizing the director of Public Health to purchase, lease, accept, or acquire suitable sites for the disposal of radioactive wastes; to provide for supervision of the operation of such sites; and to authorize the Department of Public Health to prepare and to enforce regulations pertaining to the use and operation of such sites.
5. S.B.835, providing that the Department of Public Health has the power to acquire land where radioactive wastes can be disposed.
6. S.B.836, requiring employers to provide an approved film badge radiation monitoring service for those employees subject to radiation exposure; records to be furnished by such service to the department.
7. S.B.837, appropriating $30,000 to the department to maintain a registry of film badge monitoring records and regulate film badge monitoring services.

Thus, by 1963, Illinois became the first state to implement a specific law requiring personnel monitoring and reporting. As a result of this action, a permanent repository for storage and retrieval of personnel monitoring data was incorporated in the department's electronic data processing system. This record system and its application is consonant with the requirements of the Workmen's Occupational Diseases Act in cases of claims for radiation injury in that the Industrial Commission may verify such exposures by records on file in the central registry of the Department of Public Health. This dual mechanism may, in the future, be utilized to establish cause–effect relationships of radiation exposures resulting in injuries.

In addition to carrying out the mandates of the above-mentioned legislation, on October 3, 1966, the department succeeded in having the Nuclear Engineering Corporation deed 20.6 acres of land in northwestern Illinois near Galesburg to the department on which

low level radioactive wastes were to be and are being buried. Under the department's supervision, the burial site was operated by the aforementioned corporation and a royalty of a fixed sum per cubic foot of buried waste material paid to the state.

With the authority thus vested in the department by all the above-named statutes, the radiological health activities became a substantial and extremely important factor in the protection and the maintenance of the public health.

On August 11, 1967, the governor approved S.B.984 to require registration of laser systems; to authorize the department to investigate and inspect all laser systems in the state; to require reporting of accidental injuries sustained by such laser systems; and to provide injunctive relief and penalties for violations. Few systems were registered and the anticipated hazards did not develop. The department's efforts were mostly directed to the medical use of X rays, resulting in a marked reduction in exposure to the public and the medical personnel involved through proper shielding, personnel dosimeters, use of fast X-ray film, and employment of proper techniques.

In 1969, Illinois' first radiation exposure limit was applied to the use of photo-fluorographic X-ray machines for chest radiography.

Approved on July 10, 1971, was an amendment to the Radiation Protection Act to provide for department licensure of possessors of radium and radioactive material produced artificially (accelerator produced radionuclides) in excess of exempt quantities, at such time as Illinois became an "Agreement State."

In April of 1971, a thermoluminescent dosimetry (TLD) system was first implemented at the Quad-Cities Nuclear Power Station near Cordova. This site was selected as a primary target so that preoperational data could be obtained prior to the loading of the fuel. In addition to the ongoing surveillance program, the Dresden Complex was included in the TLD system in May of 1971. The monitoring program at Dresden was most extensive, due to the establishment of a complex of three nuclear reactors and the Midwest Fuel Reprocessing Plant on adjacent sites. The Zion Nuclear Power Station was included in the TLD monitoring network system in November 1971.

A radiation exposure limit for intra-oral dental radiography became effective on January 1, 1973.

The Radiation Protection Act was again amended on October 1, 1973, to provide for licensure of all radioactive materials, devices, or equipment utilizing or producing materials that are not regulated by the U.S. Nuclear Regulatory Commission, to become effective Janu-

ary 1, 1974. An annual application fee was established for users of such material and for manufacturers and/or distributors.

Also in 1973, the Division of Radiological Health conducted a year-long federally-financed pilot study for the U.S. Environmental Protection Agency. This study, known as the Comprehensive Radiation Assessment Study (CRAS), involved the development of a comprehensive population radiation study in which *all* known sources of radiation (natural, housing, occupational, medical, and consumer products) were assessed and the total exposure determined on a selected geographic basis.

The same year, the Department of Public Health entered into a contract with the U.S. Nuclear Regulatory Commission to perform direct effluent sampling and analyses of gas, particulate, and water discharges. Samples were collected and split with the nuclear station laboratory and the results compared. Through this program, monthly discharge data routinely supplied by the utility can now be directly assessed as to analytical accuracy.

The Department of Public Health entered into another contract in 1974 with the U.S. Nuclear Regulatory Commission and the U.S. Department of Transportation to perform a three-month study involving the transportation of radioactive materials. The study was primarily directed toward assessment of present trends in radioactive materials shipment, condition of packages, radiation exposure to handlers, and conformance to U.S. Department of Transportation Regulations, Title 49 CFR.

The environmental surveillance program was expanded in 1974 to include preoperational monitoring of the LaSalle County stations, which were scheduled for operation in the late 1970s. Plans were also being developed to expand the surveillance activities to include three reactor complexes scheduled for Byron, Braidwood, and Clinton. Also, the department's Division of Laboratories obtained new instrumentation and facilities for direct support of these radiation control activities. The expansion included the addition of a Canberra Ge-Li analytical device and development of a specific radiochemical preparation room.

A Medical Use Advisory Board was created as a subcommittee of the Radiation Protection Advisory Council under authority of Section 7 of the Radiation Protection Act. This board is comprised of six highly competent M.D.'s and Ph.D.'s with extensive training and experience in nuclear medicine, radiation therapy, and medical physics.

In January, 1975, the nation's first regulations limiting medical

exposure became effective in Illinois. These regulations were developed after analyses of data accumulated during radiation facility inspections since 1971. In 1977, there were over 37,000 radiation exposure measurements stored in the department's electronic data bank system, which is the largest state data bank onpatient-exposure information in the nation.

In 1977, negotiations began with the National Bureau of Standards for the development of a Springfield-based regional radiation calibration facility. Under this contract, the department would obtain equipment and training from the federal government to implement and operate a center for calibrating regulatory instruments used to measure radiation exposure. This facility, if and when established, would be the only state facility of this type in the country.

Nuclear Safety

The 78th General Assembly amended the Radiation Protection Act (H.B.1300), authorizing the department to monitor and govern the transportation of radioactive material in the state and to act to protect the public health when conditions exist that constitute a substantial threat to health. To carry out this mandate the Division of Nuclear Safety was established by Doctor Lashof on December 19, 1975. In addition to these functions, the new division was assigned activities formerly in the Division of Radiological Health:

1. Health and safety inspections of nuclear fuel cycle facilities.
2. Radiation surveillance in the environs of nuclear fuel cycle facilities.
3. Radioactive waste management.
4. Emergency preparedness for, and response to, nuclear fuel cycle facility accidents.
5. Transportation of radioactive material.

Although these activities have been referred to under "Radiological Health," a brief repetition at this point will provide the next historian with a starting point in detailing the activities of the Division of Nuclear Safety.

Nuclear Safety responsibilities started with the Division of Radiological Health by the passing of the Radiation Installation Act in 1957, the Radiation Protection Act in 1959, and the Radioactive Waste Act and Personnel Radiation Monitoring Act in 1963.

Radiation monitoring of the Illinois environs began in 1957 with the Dresden Unit 1 Nuclear Power Plant and is being continued in 1977 for all other nuclear fuel cycle facilities through a contract

between the Illinois Department of Public Health and the U.S. Nuclear Regulatory Commission. Also, in 1973, the first annual radiological inspections of nuclear fuel cycle facilities began.

Radioactive waste management began in 1967 when California Nuclear purchased the Sheffield Waste Site property and deeded it to the State of Illinois for the burial of nuclear waste. In June, 1968, California Nuclear sold the business to the Nuclear Engineering Company. A waste site perpetual care fund of $0.05 per cubic foot of waste was established in 1967 and raised to $0.10 per cubic foot in January of 1977.

The Illinois Radiological Assistance Plan was developed in 1957 and included the Department of Public Health's responsibilities in an emergency involving nuclear fuel cycle facilities and the transportation of radioactive material. This Radiological Assistance Plan has been continually updated since 1959 to account for changing responsibilities as rules and regulations require them. To date (1977), no nuclear fuel cycle facility or transportation emergencies are known to have occurred that have threatened the health and safety of the Illinois populace.

In the spring of 1977, the department concluded negotiations with the U.S. Nuclear Regulatory Commission to obtain equipment for the surveillance of radioactive shipments on Illinois highways. Previously in November, 1975, the department had adapted, by reference, the portions of the federal regulations (49CFR) relating to radioactive material transport. After adaption, the department decided to test a monitoring system employing state police personnel and newly developed radiation detectors. In June of 1977, the program got under way with ten police cruisers monitoring Illinois highways.

Public Water Supplies

The departmental unit responsible for maintaining the safety of public water supplies was transferred in 1970 to the Environmental Protection Agency. From 1961 to the time of the transfer, this unit, called the Bureau of Public Water Supplies, administered the Public Water Supply Control Law and the Swimming Pool Law and carried out inspections of watering points used by common carriers. The latter was done for, and in the name of, the U.S. Public Health Service. In promoting the development and maintenance of safe and adequate public water supplies and safe public swimming facilities, the bureau's principal activities included the review of engineering plans and specifications for proposed construction of water works systems and pools; consultation on technical problems relating to

design and operation; coordination of inspections; and review of routine daily operating reports.

On June 25, 1963, the Public Water Safety Operator Certification Law was enacted requiring that each public water supply must employ, by June 25, 1965, at least one operator certified as "competent" by the Department of Public Health. This law gave official status to the training program for operators, which had been a substantial activity of the bureau for many years. Changes in municipal administrations frequently resulted in the removal of trained operators. This law at least made it possible to keep one fully capable operator on the job at all times.

On July 18, 1967, the Public Water Supply Act was amended (S.B.516) to require owners or official custodians of public water supplies to fluoridate the water. The efficacy and desirability of fluoridation was argued pro and con throughout the state for many years preceding this mandatory legislation. The opposition was well-organized and vehement. The responsibility for fluoridation was shared by the Bureau of Public Water Supplies and the Division of Dental Health. The engineers were assigned the responsibility for ensuring the technical aspects of the installation and operation of the chemical feeders of sodium fluoride while the dentists were assigned the responsibility for collecting samples and for surveillance of fluoride content from laboratory results.

Subsequently, all responsibility was transferred to the environmental unit of the department. In 1970, all aspects of the public water supply program, except the responsibility for fluoridation, were transferred to the Environmental Protection Agency.

Air Pollution Control

In 1961, when Doctor Yoder began his administration, air pollution control activities were centered in the Bureau of Radiological Health and Air Pollution Control of the Division of Sanitary Engineering. The principle activity was to provide technical assistance to communities that requested assistance in evaluating their local air pollution problems.

In fiscal year 1962, a law was enacted creating an advisory board to the department with jurisdiction in the counties of Cook, Will, McHenry, Kane, Lake, and DuPage. This board was known as the Northeastern Illinois Metropolitan Area Air Pollution Control Board. The board was organized in the spring of 1962 and began its investigation of air pollution problems at the request of local officials, department personnel providing the technical assistance.

The 73rd General Assembly enacted and the Governor approved on August 19, 1963, the Illinois Air Pollution Control Act authorizing a board to prevent, abate, and control air pollution throughout the state. The previous bill creating the metropolitan area board was repealed. The new board was an independent agency and was designated as the agency to represent the state in matters of interstate air pollution problems. The chief sanitary engineer of the state (chief of the Division of Sanitary Engineering) was designated as technical secretary of the board, with the personnel of his unit to provide the necessary technical work. This work involved investigations and studies for air pollution and sampling of the atmosphere for levels of pollutants. It should be noted that this legislation made provision for certificates of exemption to those local governments having an effective air pollution ordinance adequately enforced.

Much of the next year-and-one-half was spent in organization, in formulating criteria, in preparing to form an interstate air pollution control compact with Indiana, in preparing rules and regulations, in establishing an air pollution laboratory in Springfield, and in developing a comprehensive air resource management program with funds made available by the U.S. Public Health Service through provisions of the Federal Clean Air Act of December 1963.

The 74th General Assembly passed H.B.1224 and Governor Kerner approved the legislation that ratified and approved the Illinois–Indiana Interstate Air Pollution Control Commission. It carried an appropriation of $10,000. Similar legislation was enacted by the state of Indiana, a prerequisite for consideration by the U.S. Congress of all interstate compacts. For reasons unknown, the compact never materialized.

To clarify the department's dilemma in furthering the cause of air pollution control, the combined federal and state funds available for this activity in fiscal 1964 was a mere $124,470.

In an effort to give the air pollution control function more visibility and status, it was separated from radiological health and called the Bureau of Air Pollution Control. Plans were developed for obtaining five mobile trailers to serve as semipermanent air sampling sites equipped with continuous monitoring equipment.

The 75th General Assembly enacted the following legislation approved by the Governor:

1. An amendment to the Air Pollution Control Act permitting injunctive action during an administrative review procedure.
2. An amendment to "An Act in Relation to the Regulation of Traffic" requiring an adequate muffler or exhaust system on every motor vehicle.

3. Amendments to the "Review Act of 1939" providing relief from real and personal property taxes for air pollution control equipment.
4. Amendments to existing statutes authorizing local governments to contract with each other for air contamination control.

By fiscal year 1970, the bureau was installing its first telemetry equipment to establish four ambient air sampling stations in various locations to sample air continuously on a twenty-four-hour basis and transmit data instantly to computer facilities in Springfield. Accomplishments in working with municipalities and industry were substantial. Illinois was among the first states in the nation to establish an alert system and to obtain agreements with certain commercial and industrial facilities to cease operations during alert conditions.

With the acceleration of interest in ecology, the new governor (Richard B. Ogilvie) had emphasized his interest in environmental controls and, to give visibility to this interest, created, through legislation, the Environmental Protection Agency, which took over the air pollution control program in 1970.

Water Pollution Control

In 1961, the departmental unit responsible for the prevention and abatement of pollution of the surface waters of the state was the Bureau of Stream Pollution. In the light of later developments, the title appears to limit unnecessarily the broad functions of this unit. Even the implication of "control" was missing from its name. Nevertheless, this unit, over the years of its existence, was highly regarded for its accomplishments and aggressive pursuit of its objectives—or more accurately, the objectives of the Illinois Sanitary Water Board.

The Illinois Sanitary Water Board, created in 1929, was, by law, the agency vested with the authority to prevent and abate water pollution, while the Department of Public Health was the legal agency through which this authority was exercised. The technical secretary of the board was, by law, the chief sanitary engineer of the department, who brought to the attention of the board such matters as he deemed proper. The board based its actions and decisions on information provided by him. By precedent, the director of Public Health was usually the chairman. Appropriations for carrying out water pollution control activities were made to the department rather than the board.

The principal services rendered by the water pollution control unit

have been (1) surveillance of the quality of the surface waters of the state; (2) review of design plans and specifications for all construction involving sewage, sewage treatment works, and industrial waste works having outlets to surface waters where fifteen or more persons were to be served; (3) issuance or denial of construction permits; (4) routine inspection of sewage and waste treatment works for maintenance and operation; (5) training of operators; (6) surveys of fish-kills, oil spills, and mine drainage; and (7) investigation of complaints.

Federal grants for construction of sewage treatment works became available in the mid 1950s under Public Law 84–660 (as amended). An additional source of federal grants for the same purpose became available in the fall of 1962 under the Accelerated Public Works Act. This, of course, proved highly beneficial in improving the quality of the state's surface waters and added a tremendous workload to the program. In some cases, however, municipalities hesitated to proceed on their own with needed treatment facilities, hoping to become eligible for a grant.

The number of inspections, plan reviews, investigations, and surveys carried out by this unit are legion. That its functions were transferred to the Environmental Protection Agency in 1970 in no way implies dilatory effort or lack of accomplishments.

Miscellaneous Environmental Activities

Nuisance Complaints—Such complaints have been abundant over the years and in every possible variety—odors from a neighboring pig sty, water shut-offs for lack of bill payment, farm animals maintained within city limits. These are but a sample of what people brought to the attention of their State Department of Public Health. In the great majority of cases, the department was powerless to act although complainants were given advice and frequently referred to their local officials when it was known that correction was within their authority.

Bottled Water Program—The safety and potability of bottled water was a responsibility transferred along with the food and dairy program from the Department of Agriculture. This was never an active program although occasional samples were collected on special request.

Mass Gatherings Act—An act to regulate mass gatherings, approved on August 4, 1971, required promoters of any mass gatherings to obtain a written permit from the department and to post bond

and furnish evidence of insurance before a mass gathering was set up, held, or promoted. It also provided for forfeiture of bond in case of violation of the permit. This law was the result of a few so-called "rockfests" held in the state at which highly unsanitary conditions existed that were deleterious to health. Since its passage, there have been no licensed rockfests in the state.

Lead Poisoning Prevention Act—This act was passed in 1973 in response to the increasing number of children found with elevated blood-lead levels. Children most often get lead poisoning by ingesting paint chips containing high levels of lead. The law sets the maximum allowable lead content in paint, provides for reporting of children with elevated blood-lead levels, and requires homeowners to remove or permanently cover lead-bearing substances. In this way the child is protected from further exposure to lead, which has a cumulative effect.

The medical aspects of this program have been the responsibility of the Division of Disease Control. The Environmental Health staff perform inspections of homes of children with elevated blood-lead levels. The homes of more than 1,200 children have been inspected since the program began. The department originally purchased one X-ray lead analyzer for inspections and, in 1977, had a total of seven instruments available to regional personnel.

Poison Prevention Packaging Act—Enacted in 1972, this act protects the consumer by requiring child-resistant closures on packages of certain hazardous substances.

A 40 percent reduction in poisonings caused by aspirin has been achieved since it has been required to be in child-resistant packaging. The department has performed more than 1,000 inspections to determine compliance with the Poison Prevention Packaging Act. By 1977 there were fourteen products requiring child-resistant closures.

Refuse Disposal

For many years the department had provided technical assistance, on a request basis, to municipalities concerning the operation of dumps, the use of landfills, the choice of sites, etc. The department's involvement became statutory with the enactment in 1965 by the 74th General Assembly of "An Act Relating to the Registration and Regulation of Refuse Disposal Sites and Facilities." This bill (H.B.1458) carried an appropriation of $20,000 and provided for a five-member advisory board to be appointed by the Governor. Rules

and regulations relating to design, location, construction, operation, and maintenance were promulgated on March 22, 1966.

The areas of high population density, where there were known problems from previous requests, were given priority consideration. During fiscal year 1966–1967, approximately 2,000 site inspections were made; seventy open burning dumps were converted to sanitary landfills, and 250 dumps were closed. The next year, 340 dumps were closed; 307 of these were covered, and 130 new landfills were started. By June of 1969, over 300 sanitary landfills had been established. Another 273 dumps were closed in fiscal year 1969. By June of 1970, the number of sanitary landfills had jumped to 716.

On September 8, 1969, H.B.2737 was approved. This bill authorized the organization of solid waste disposal districts, with the department responsible for the technical aspects involved. This law was never fully implemented before all refuse disposal and solid waste programs were transferred to the Environmental Protection Agency in 1970.

Sanitarian Registration

From September 1961 through 1977, the department section concerned with the environment has been known as the Division of Sanitary Engineering (Yoder), the Bureau of Environmental Health (Yoder), the Office of Consumer Health Protection (Lashof), and the Office of Environmental Health (Peterson).

The foregoing pages have attempted to document the work and accomplishments of this unit, whatever its name. That it has been a major arm of the department in the maintenance and promotion of the public health is manifest from the foregoing recital.

It should be recorded here that in the earlier years a Bachelor's Degree in sanitary engineering or a closely allied academic background was essential to employment in a responsible position. Over the years, there developed a new concept of personnel in matters of the environment—the "sanitarian." This resulted primarily because (1) sanitary engineers were in short supply, and competition for their services was intense; and (2) many functions and activities within the field of environmental health neither required nor appealed to an engineer. The 74th General Assembly passed, and Governor Kerner approved S.B.243, which created the Sanitarian Registration Act. This statute provided for the licensing and registration of sanitarians by the Illinois Department of Registration and Education and created the Board of Registration for Sanitarians in that department. This

proved a boon to the environmental efforts of the Illinois Department of Public Health and to local health departments. Likewise, it provided the stimulus to various universities in Illinois to go ahead with academic training in the field of sanitation.

Chapter 3

DENTAL HEALTH

A Brief History

A program for the improvement of dental health was first undertaken by the department in 1926 with funds provided by the Illinois and Chicago Dental Societies and the Illinois Tuberculosis Association. The next year, and thereafter, until November 1, 1935, funds for dental health came from an appropriation made to the Division of Maternal and Child Hygiene. The Division of Dental Health was created on November 1, 1935.

From that time until 1942, the dental health program was described as "purely educational." In 1942, the practice of paying for remedial work for underprivileged children was started by the department. From 1948 to 1960, X-ray surveys were made of the teeth of school children, and the parents of those children in need of remedial care were urged to consult a private dentist. In 1948, the division began to devote attention to topical applications of fluoride and to the fluoridation of public water supplies following the favorable reports of the Evanston fluoridation study subsidized by the department.

Doctor John Zur, chief of the Division of Dental Health at the time of Doctor Yoder's appointment to the directorship, resigned to accept a position with the American Dental Association and was succeeded on August 1, 1962, by William Greek, D.D.S.

Responsibilities and Policies

Throughout the Yoder administration, the dental health unit was made responsible for the design, implementation, and evaluation of programs that had as their purpose the prevention and control of dental diseases and the promotion of dental health through orga-

nized community efforts. The community in this frame of reference included the area and the population of the state of Illinois. Programs specifically designed to prevent and control dental diseases were organized and operated to assist in meeting the departmental objective of "improving community health." It was recognized that significant progress toward the realization of this goal required the cooperation of the private practice sector and official and voluntary agencies. The division actively strived for a high degree of cooperation among all facets of health improvement organizations in carrying out its programs. These programs remained basically unchanged from descriptive data contained in the several annual reports preceding the July, 1973–June 30, 1974 annual report. Priorities were adopted by legislative mandate and the needs of the population. Thus, the fluoridation of public water supplies became an important program of the division. Other programs included school dental health, dental education, mobile dental clinics, dental care development and delivery, interaction with professional organizations, and special projects.

Water Fluoridation—The Evanston water fluoridation study, and similar studies in Newburgh, New York; Grand Rapids, Michigan; and Brantford, Ontario, all led to the conclusion that controlled fluoridation of public water supplies successfully and safely reduced the incidence of dental caries in children. The Illinois State Dental Society, on January 12, 1951, adopted a resolution endorsing and encouraging the fluoridation of public water supplies for Illinois communities "provided such communities have the endorsement of the local dentists and can meet the standards required by the Department of Public Health for safe and efficient operation." On August 8, 1951, the department adopted a policy favoring fluoridation and launched an aggressive program of promoting this treatment of the public water supplies in Illinois.

In many instances, strong and bitter opposition was met, and the proposition was defeated in several local referenda. Despite a well organized effort by opponents of fluoridation, 148 municipalities, including Chicago, representing altogether some 5,250,000 people, had begun fluoridation of their public water supplies by the end of 1962. By June of 1967, this number had risen to 196 communities and 5,933,600 people. At this time, there was a total of 6,561,900 people in Illinois drinking water that either contained sufficient natural fluorides or was being artificially fluoridated to 1.0 parts per million. Mandatory fluoridation in Illinois was first considered in February, 1966, during the mid-winter dental meeting in Chicago. The Committee on Dental Health Education of the Illinois State Den-

tal Society at that time recommended to the executive council of the society that an effort be made to see if mandatory fluoridation might become a reality in Illinois. The executive council approved the suggestion, and it was made a part of the Illinois Dental Society's legislative program. On August 4, 1966, a group from the Illinois Department of Public Health and the Illinois State Dental Society met to consider plans for the adoption of such a program. Those in attendance at this meeting included Doctor William J. Greek, executive secretary of the Illinois State Dental Society and former chief of the dental division; Doctor Wilbur Reece, chairman of the Legislative Committee; Doctor Robert Norton, chairman of the Committee on Dental Health Education; Doctor Franklin D. Yoder, director of the Illinois Department of Public Health; and Doctor Carl L. Sebelius, who had been appointed to succeed Doctor Greek as chief of the Division of Dental Health on March 1, 1966.

The main discussion centered around which path to follow, whether it should be made mandatory through an established regulation or whether legislation should be introduced. The consensus was that the issue was no longer purely scientific, but political as well. After consultation with Mr. Robert Gleason, legal counsel for the Department of Public Health, and after his discussions with the attorney general's office, it was decided that legislation was the path to follow.

An organization composed of approximately 900 dentists called "LICID" (Legislative Interest Committee of Illinois Dentists) came into the picture. This group established mechanisms whereby the influence of the dental profession was exerted in the executive and legislative branches of the state government and their various administrative agencies. LICID became a driving force behind the effort to secure fluoridation. Letters were sent to county and city health departments and regional offices urging support.

Russell Arrington (Evanston), president pro tempore of the senate, was contacted to obtain his reaction to the bill calling for mandatory fluoridation. He was enthusiastically supportive and delegated his son, Mike, who was serving as his legislative assistant, to draw up an amendment to the public water supply act. Senate Bill 516 was sponsored by Senator William Horsley of Springfield.

During the senate hearing, conducted by the Committee on Welfare, only one person appeared to testify against the bill. However, when hearings were held in the house, the opposition had gathered forces and was much in evidence. The so-called Pure Water Committee was well organized in opposition, and a number of out-of-state individuals were brought in to speak against the bill. The

bill was first assigned to the Commission on Welfare and then changed to the Committee on Municipalities by the speaker of the house.

There were to be no debates. Mr. Carl Meyer, legal representative for the Illinois State Dental Society, had the same procedure followed in both the house and senate.

Those who testified in favor of the bill included Doctor Roy Doty, secretary of the Council on Dental Therapeutics, American Dental Association; Doctor Thomas K. Barber, professor of pedodontics, University of Illinois School of Dentistry; Doctor John Spence, assistant dean of the University of Illinois School of Dentistry; Doctor Franklin D. Yoder, director of the Illinois Department of Public Health; and Doctor William J. Greek, executive secretary of the Illinois State Dental Society.

At the conclusion of the hearing, Mr. Meyer read a letter from the director of the Department of Public Aid recommending mandatory fluoridation, and a three-page telegram received from the surgeon general of the United States Public Health Service.

The Committee on Municipalities voted "do pass." The bill passed the house by a 101 to 46 vote and was signed into law by Governor Kerner on July 18, 1967.

After Senate Bill 516 became law, it became an important part of the Division of Dental Health's activities to implement the terms of the law and to promote and enforce the act. The administration was to be handled by the Division of Sanitary Engineering, which was responsible for the public water supply program.

In August, 1967, regulations were sent to all mayors, council members, and water superintendents in Illinois. The regulations set April 1, 1968, as the date for the receiving of fluoridation plans and July 1, 1968, for fluoridation to be in operation. By 1973, some nine million people in Illinois were drinking fluoridated water.

When the public water supply control program was transferred in 1970 to the newly created Environmental Protection Agency, the fluoridation responsibilities remained with the Department of Public Health in the Division of Dental Health. By 1973, the fluoridation program, insofar as the department was involved, became one primarily of surveillance with water samples being sent to, and analyzed by, the department laboratories. The laboratories then sent the results to the Division of Dental Health for review and enforcement, if necessary. Approximately 10 million people in Illinois were drinking fluoridated water by 1974. On July 1, 1975, all departmental fluoridation functions and duties were delegated to the Office of Consumer Health Protection (formerly Environmental Health).

Mobile Dental Clinic—The mobile dental clinic program was initiated in 1966 when a surplus chest X-ray van was obtained by the Dental Division and converted into a mobile dental van. Funds for conversion were obtained through the Migrant Farm Labor Act; thus the van was required to be utilized to provide dental treatment to migrants during the harvest season, which roughly coincided with the school vacation period, and to service school children during the "normal" school year. The program was well accepted; and, in late 1969, a new van was obtained and placed in service. The type of funding this time did not require restricted use and so the van was utilized on a year-round basis to provide dental care and treatment for school-aged children throughout the state.

Funds were unavailable for additional vans and routing the unit throughout the state was necessarily stopped in 1972, restricting the area covered to the southern one-third of the state.

Patients' eligibility for clinical attention was not formally restricted but priority was given to low income families. The children were screened by a school nurse or by local health department personnel prior to the arrival of the van. Final determination of patients to be treated was made by the department dentist assigned to the van. The number of patients treated on an annual basis varied from 800 to 1,000, and approximately four dental procedures were accomplished for each patient accepted for treatment. No attempt was made to provide service comparable to the sophisticated procedures available in a fixed dental office. Treatment was restricted to diagnosis, oral hygiene, operative dentistry, and minor oral surgery. Dental health education was emphasized with self-help procedures stressed on a one-to-one basis.

Prior to the van's arrival at a preselected site, usually in proximity to a school, clearance was obtained from local dentists, dental societies, school administrators, and local health departments. This service was not construed as being in competition with local dental practitioners but rather as an adjunct to the practitioners.

This activity, eagerly sought by the schools, continued through 1977 with the one van serving the southern one-third of the state.

One direct result of routing the mobile unit to the Winnebago County area as a demonstration project was the purchase of a modern dental mobile unit by the Winnebago County Health Department and the employment of a full-time dentist to serve as a clinician.

School Dental Health—During the period of 1968 to 1974, the school dental health program was one of the dental division's highest priority efforts. Entry into the school setting provided the

division with the opportunity to develop in the school-aged child correct and beneficial dental health practices.

In 1968, the division introduced a new dimension to the school program in the form of a self-applied topical fluoride procedure. This preventive measure, together with the educational components, was designed to emphasize the prevention aspect that is the guiding principle of all public health.

Those children in kindergarten through the sixth grade were the primary target of the school program; the children in kindergarten and grades one and two were given information, toothbrushes, and color books while the older children participated in the application of fluoride since they had the manual dexterity to handle the tooth-brushing technique. In some schools, the program was carried through all grades including high school, but only on request of the local superintendent since the division was limited by funds and manpower.

The number of children reached with this direct service was second only to those receiving the benefits of water fluoridation. Originally started in 1968 as a demonstration project involving 16,000 students, the program served close to a million by the close of fiscal year 1973. The division provided the fluoride prophylactic paste, toothbrushes, coloring books, and other literature, while the individual school was responsible for supplying paper cups and napkins.

The main constraint in this program was the manpower needed to conduct it. When there were comparatively few programs in the schools, the regional dental consultants provided the instruction. The program, however, grew to the point where it was necessary to utilize other available resources such as school and public health nurses, dental students, dental hygiene students, student nurses, and teachers. These volunteers were first given in-service training by the dental consultant until it was felt that they were able to conduct the program. Even with this help, there were many areas where there were few or no willing volunteers and the dental consultants necessarily presented the program.

Since the introduction of the program in 1968, almost all schools visited have requested an annual repeat of the program.

In 1973, the division put its school program formally into writing in a pamphlet entitled, "Your School Dental Health Program." This publication was sent to all superintendents of public school districts by the Office of the Superintendent of Public Instruction.

A school-related activity of the division was to act as an advisor to the Office of the Superintendent of Public Instruction to implement

House Bill 2547, mandatory health education legislation, in which dental health was a required subject to be included in the school curriculum.

In May, 1974, all school superintendents in Illinois were requested to eliminate the sales of sweetened beverages and confections from the school to help prevent tooth decay. The request from the state health department's Division of Dental Health was in support of the American Dental Association's policies on the sale of sugar-rich products in schools. An interview over WICS-TV in Springfield concerning the proposal resulted in a rerun of the discussion over the NBC network.

Midway in the Lashof administration, this program was terminated.

Dental Public Health Residencies—The dental public health residency program was established in 1967 under the immediate supervision of the chief of the Division of Dental Health. The residency was fully approved by the Council on Education of the American Dental Association. Funding was obtained through a Department of Health, Education, and Welfare grant for a five-year period from July 1, 1968, to June 30, 1973. Requests for continuation of funding were required on a yearly basis. Due to budgetary restrictions at the federal level, funds to carry on this program were no longer available after June 30, 1973.

During the five-year period, July 1, 1968, to June 30, 1973, ten dentists successfully completed the residency and six of them were employed in the Division of Dental Health.

The purpose of the residency was to provide recent graduates of schools of public health with field experience, under direction, and the opportunity to apply academic knowledge in a practical situation. A secondary purpose was to meet one of the requirements necessary for an individual to sit for the American Board of Dental Public Health.

Dental Manpower Survey— In early 1974, the division entered into a Dental Manpower Survey Study designed to obtain current information regarding dentists in Illinois and facts concerning the character of their practice as well as the distribution of dentists and the availability of their services. Divisional input into this activity consisted of gathering information from 8,336 Illinois licensed dental practitioners through a form sent to all dentists as they renewed their licenses with the Illinois Department of Registration and Education. The results were made available in booklet form in the early part of 1975 .

Dental Care Delivery—A major responsibility of the division has

been to represent dentistry and to bring about its inclusion in all programs that were directed at the improvement of the overall health of the residents of Illinois. To this end, the division has played a significant role in the following programs and activities:

- *Medichek:* Implementation of the dental aspects of the Medichek program required the development of guidelines regarding the provision of dental care that was to be rendered through the private practice sector and health oriented agencies. This, of necessity, required the acceptance of the program by the providers of care, and acceptance was obtained through close liaison with organized dentistry represented, in this instance, by the Illinois State Dental Society which first approved the program.
- *Head Start:* Division staff served as consultants to head start programs carried on throughout the state. In this capacity, all full-year head start programs were evaluated and program planning was provided for upgrading of anticipated and ongoing programs. The mobile clinic was utilized when possible to provide direct dental care and treatment for children enrolled in head start.
- *Geriatrics:* In the area of geriatrics, the dental hygienists and dental consultants conducted in-service education programs for staffs of long-term-care facilities, explaining oral disease processes common to the aged, as well as methods for eliminating or controlling these diseases.
- *Local Health Departments:* To encourage the development of aggressive dental programs at the local level, division staff members worked with local health departments to make them aware of the need for public-funded dental programs in their areas. They also assisted in upgrading the existing programs in their areas and in initiating new dental programs through education, grant preparation, and recruitment of dental personnel. As a result of these efforts, dental programs were developed at Tri-County Health Department, Lake County Health Department, and Winnebago Country Health Department.

  In 1972, the division was successful in securing surplus new federal dental equipment for local health facilities through a cooperative arrangement between the Division of Dental Health and the U.S. Public Health Service of the Department of Health, Education, and Welfare, in which the department was to be responsible for compliance with federal guidelines. Agencies that received equipment included the Chicago Board of Health, Cook County Department of Public Health, Stickney Township

Public Health District, Will County Health Department, and the Olney Central College of Dental Hygiene. The transfer consisted of eighty dental chairs and eighty dental units having a value of $112,240.

- *Higher Education:* In the area of higher education, the division assisted departments of public health dentistry in the major dental schools in Illinois with planning, developing, and conducting dental public health courses. For two years, staff members conducted a course in community dentistry at Loyola University Dental School. During the school years 1971–73 and 1973–74, a course in dental public health was presented at the University of Illinois Dental School. The division also assisted the Southern Illinois University Dental School at Alton.

Commentary

The Division of Dental Health retained that title during the Lashof administration and with reorganization, became one of five divisions in the Office of Health Services and Local Health Administration. It should be noted that the basic functions of the division remained about the same for the first few years as they had been under the Yoder administration. Subsequent major changes did take place.

Economy of operation, to the extent possible, while still maintaining effective services, has always been an objective of the department. The Lashof administration focused upon the Division of Dental Health, among others, to determine the effectiveness of its activities and the results thereof in comparison with the cost of providing the ongoing services. Bruce L. Douglas, D.D.S., M.P.H., the head of dentistry at Presbyterian–St. Lukes Hospital in Chicago and a former state representative, was employed contractually on January 1, 1975, by the state coordinator of health, Doctor Mark Lepper, to make a study of the department's dental health program.

It appears from the study that the employment of regional dentists was considered unnecessarily expensive and that their responsibilities could be adequately fulfilled by dental hygienists. This led to the departure of regional dental consultants as their jobs were abolished, and their replacement by dental hygienists.

At about the same time, the dental health programs in schools were phased out.

On July 31, 1975, the chief of the dental health division, Carl L. Sebelius, D.D.S., resigned. He was replaced by Bruce L. Douglas, D.D.S. On September 1, 1977, he, in turn, was replaced as chief of the division by William L. Babeaux, D.D.S.

Chapter 4

DISEASE CONTROL AND CHRONIC ILLNESS

A Brief History

The heading, "Disease Control and Chronic Illness," may appear in some ways to be redundant since the chronic illnesses may be classified as diseases. Historically, disease control and chronic illness programming were separate functions administratively in the department. Only in recent years has disease control included the chronic illnesses. For the first nine years or so of this chronicle, disease control efforts were limited essentially to the communicable diseases in what was known as the Bureau of Epidemiology. Except for tuberculosis, which was a separate responsibility of the Division of Tuberculosis Control, the chronic illness efforts were assigned to what was called the Bureau of Chronic Illness in the Division of Health Care Facilities and Chronic Illness.

In the reorganization of 1970, the Bureau of Personal and Community Health was established as the supervisory unit for, among others, the Division of Disease Control and the Division of Chronic Illness; the latter assuming responsibility for the tuberculosis control program.

Finally, in the course of changes made during the Lashof administration, the Division of Disease Control, in the Office of Health Services, was made responsible also for the chronic illnesses.

Tuberculosis Control—The unit responsible for this program has been a separate division reporting directly to the director (1961); a unit of the Division of Disease Control under the Bureau of Personal and Community Health (1970); and a unit of the Division of Disease Control under the Office of Health Services (1974).

The detailed history of tuberculosis control efforts in Illinois provides interesting and intriguing reading and can be found in

previous volumes, in annual reports of the department, and in a volume entitled *History, Illinois Tuberculosis Association 1905–1967* by B. K. Richardson. All of these are available from the Illinois State Library.

As early as 1899, the Illinois State Board of Health recognized tuberculosis as a devastating plague of the first magnitude. Throughout these early years, the Board and the state health officers who followed attempted to get the state to participate substantially in the organized fight against tuberculosis.

Only token appropriations for tuberculosis control were made to the Department of Public Health prior to 1941, although in 1908 a special session of the general assembly enacted a municipal tuberculosis sanatorium law permitting any municipality to establish and operate a tax-supported tuberculosis sanatorium after a favorable referendum on the proposition. In 1915, a similar law was enacted applying to counties. Both laws carried the title of their sponsor and became known as the Glackin Acts.

In 1941, under the leadership of Doctor Roland R. Cross, the department director, the first state funds in the amount of $16,600 were earmarked by the department for the fight against tuberculosis. This was the beginning of a state program that rapidly assumed major dimensions. In 1961, over $8,000,000 was appropriated for tuberculosis control, which was nearly half of the total biennial appropriation for the department in that year.

Early in the 1960s, approximately 500,000 individuals were X-rayed by department operated mobile X-ray units in an effort to discover early tuberculosis. An evaluation of an age breakdown of persons surveyed and yield of tuberculosis revealed that a relatively high percentage of those X-rayed were under thirty years of age and that very few cases of tuberculosis were found in this group. Accordingly, the department limited the program thereafter to those persons thirty years of age and over. After a few years, further studies on the yield from mass X-ray surveys indicated that the cost of finding a case of tuberculosis was prohibitive and the program was discontinued. In replacing this casefinding activity, a child-centered tuberculin testing program was substituted to find the infected individuals in the hope that this would lead to index cases among adults. This activity was geared toward grades one, five, and nine in all public and parochial schools throughout the state.

Mobile X-ray units were then limited to X-raying the reactors in the school system and their household associates. Within a few years it was recognized that even this program found only a small number of cases, largely because of the low percentage of new

reactors being identified. On September 1, 1965, the Center for Disease Control of the U.S. Public Health Service loaned a public health advisor to the state of Illinois, to assist with the objectives of the program. In 1967, a campaign was initiated to re-examine all identified tuberculin reactors among the school children and their household associates for the purpose of evaluating them for chemoprophylaxis—the procedure of administering a medicine to stop an infection before it causes clinical illness.

Program staff audited local agencies and established central office monitoring. At the same time, all significant contacts to new cases of tuberculosis were placed in priority for tuberculin testing, prophylactic treatment, and other services as indicated. Identification and treatment of significant contacts to index cases has been a continuous effort by the central office, which monitors services rendered.

The treatment of tuberculosis underwent a dramatic change with the introduction of streptomycin in 1945. The introduction of isoniazid (INH) in 1952, and other drugs in succeeding years, shortened the recovery period for many cases. Yet, because of the lack of long-term experience, hospital stays remained approximately the same. During the period of proliferation of drugs for tuberculosis treatment, the Chicago State Tuberculosis Sanatorium was designated to participate in research to evaluate the effectiveness of ethambutol and ethionamide.

The relatively rapid improvement of patients on various drug regimens made long-term hospitalization unnecessary. Within a relatively short period of time, the waiting lists at sanatoriums all over the state disappeared and bed vacancies became the rule. Chemotherapy proved to be so efficacious that sanatoriums began to close for lack of patients. This process was supported by the Governor's Advisory Committee, which was appointed by the governor in 1970. The two state sanatoriums (Chicago and Mount Vernon) were gradually phased out: Chicago discontinued serving tuberculosis patients in 1973; Mt. Vernon in 1974. The last remaining sanatorium, the Municipal Tuberculosis Sanatorium in Chicago, closed on December 31, 1975, marking the end of an era of specialized institutions for the care of tuberculosis patients. In 1977, there remained one institution in Suburban Cook County that, while originally a 150-bed sanatorium for TB, was licensed as a general hospital with provisions for inpatient tuberculosis care.

Prior to this, in July, 1971, Governor Ogilvie assigned to the department the responsibility of operating the Chicago State Tuberculosis Sanitarium as a "flexi-general" hospital. The institution

became known as the Chicago Hospital and Clinics wherein there was operated a geriatric transfer program; a drug abuse methadone clinic; medical services for a Department of Public Aid medical evaluation program; and a tuberculosis care and treatment program for a few remaining patients. In April, 1974, two other services were added: (1) the University of Illinois Sickle Cell Center, and (2) the Planned Parenthood Association Training and Research Center for Family Planning.

In 1975, the building formerly known as the Chicago Tuberculosis Sanitarium was transferred to the University of Illinois for use as a base for its Department of Family Practice.

During the closure of the tuberculosis sanatoriums, the department's tuberculosis program developed in-service training programs for selected general hospitals throughout the state. General hospitals were selected geographically at the beginning so the department could be assured that all tuberculosis patients needing inpatient care could receive such care close to their homes. As the concept of general hospital care for the tuberculosis patient became more acceptable, all licensed general hospitals were recognized as possible inpatient treatment facilities for tuberculosis patients, and inservice training programs were expanded to include these facilities.

Virtually all patients were treated on an ambulatory care basis except for the occasional patient with severe systemic symptoms. Incidence in the state of Illinois continued to decline—there were 3,895 cases in 1962 as compared to 1,711 cases in 1976.

The radically changing concepts in the treatment of tuberculosis brought about a need to revise numerous statutes relating to the disease. Counties were assigned, under the Glackin Act, the responsibility of providing free care to tuberculosis suspects and cases. Even though this legislation categorically funded tuberculosis programs, the problems of uniformity, continuity of care, and residency requirements produced a need for revisions and amendments to the existing law. These needs resulted in the formation of a Governor's Advisory Committee on Tuberculosis and provided the director of the Department of Public Health the authority to establish minimum standards. The Glackin act and the Local Health Department Act were amended to allow consolidation of the two agencies by contractual agreement. This amendment has been of such benefit that a proposed Health Services Act was introduced in the 80th General Assembly. With the decrease in productivity of screening efforts among food handlers, barbers, and school personnel, previ-

ous legislation requiring annual certification of freedom from tuberculosis was repealed.

Under auspices of the Tuberculosis Section of the U.S. Public Health Service, scores of key personnel from local health agencies were approved to participate in comprehensive training in modern techniques of tuberculosis management at the Center for Disease Control in Atlanta, Georgia. The department then developed "Tuberculosis Today" seminars that were conducted on a co-regional and statewide basis throughout the years.

From a peak of more than eight million dollars appropriated in 1961, funds available for tuberculosis continually decreased thereafter, the appropriation in fiscal year 1978 being less than $200,000.

Venereal Disease Control Program—Casefinding, screening, treatment and education have been the primary activities undertaken to attain the goal of venereal disease control—interrupting transmission of the diseases at a rate sufficient to achieve an overall decline in the incidence of the venereal diseases.

Since 1961, the number of reported cases of syphilis has fluctuated from a low of 873 in 1964 to 1,478 in 1976. Reported gonorrhea cases have risen until 1976 when the first decline was achieved in this fifteen-year period, from 20,760 in 1975 to 20,430 in 1976. Gonorrhea continues to be the number two communicable disease, exceeded only by the common cold.

In the early 1960s, venereal disease control program personnel began an intensified program of personal visitation to physicians to discuss all phases of the VD control program, to offer the services of the department, and to encourage physicians to participate in the control program. This effort was considered successful when reporting by physicians began to increase steadily. Correspondingly, epidemiologic investigations increased as reporting of infectious cases increased.

Contacts and suspects from other states and countries increased nationwide to the extent that the Center for Disease Control of the U.S. Public Health Service established the Interstate Communications Control network with specific guidelines to expedite these investigations. Incoming and outgoing referrals averaged 650 annually in the 1970s and included, in addition to the fifty states, the countries of Canada, Mexico, the Philippines, Germany, England, France, Vietnam, Nigeria, Korea, Jamaica, Brazil, and Thailand.

Where there is no public clinic for sexually-transmitted diseases, payment for treatment of a patient may be made to a private physician in accordance with a fee schedule established by the depart-

ment, and following prior authorization by a department representative. In 1961, $925.86 was paid to physicians for such services; while in 1976, $25,000 was paid, reflecting not only larger numbers of patients treated, but increased costs of services.

In September of 1969, the Minor's Consent Law was enacted, allowing minors twelve years of age and over to consent to their own examination and treatment for venereal disease. This legislation was helpful in bringing many teenagers to treatment who had been reluctant to seek medical care for fear of parental reaction. Since a high percentage of cases occur in the young adult population, this treatment helps block further spread of the disease.

The cost of antibiotics for venereal diseases, distributed free of charge to physicians, clinics, hospitals, and institutions, rose from $17,000 in 1961 to $70,000 in 1976.

Educational efforts, directed toward the general community as a whole—and to teenagers and young adults in particular—have always been a vital component of the control program. Methods including presentation of talks and films to student assemblies, community and civic organizations, and professional groups have been utilized by department representatives. Program personnel worked closely with the Illinois Office of Education to introduce venereal disease education into the curriculum of the public schools. Pamphlets, posters, bookmarks, films, radio and television programs, and other tools were all utilized to reach the largest possible number of people. The Pharmacists' Association and Jaycees participated in the VD control effort as part of their national projects.

VD Checkline, a toll-free telephone "hotline," went into operation on December 11, 1972. This service was designed to give assistance to Illinois residents having questions about the signs and symptoms of venereal diseases, or who were in need of treatment but did not know where to obtain it. This educational effort proved to be exceptionally effective and a far cry from the years when the word *syphilis* could not be used in the public media.

In 1972, due to the continued upward spiraling of gonorrhea reporting to "epidemic" proportions, a major change in direction occurred in the venereal disease program. This was the first time in the history of the program that gonorrhea control became the primary objective. To implement this effort, the federal government greatly increased its assistance to the state.

A program was initiated to detect, treat, and remove asymptomatic female gonorrhea patients from the reservoir of infectious patients. An expanded field staff recruited over 300 health providers to initiate

routine screening of female patients between the ages of fifteen and forty-five. Media for performing gonorrhea cultures, pick-up and delivery service, and laboratory services at the state laboratory are supplied by the department free of charge to health providers where necessary. Since the start of the program, the ratio of reported male gonorrhea cases to female gonorrhea cases has decreased significantly from 3.14:1 in 1970 to 1.42:1 in 1976.

Additionally, as part of the new program direction, priority is placed on gonorrhea epidemiologic activity with emphasis being given to interviewing infected females to determine contacts.

The introduction into the United States of *Penicillinase-F producing Neisseria gonorrhoeae* has presented a problem for the venereal disease control program. Since this strain of gonorrhea does not respond to penicillin, it requires treatment with a different antibiotic. A large-scale outbreak would require a complete revision in recommended treatment schedules and, if not discovered promptly, could spread to epidemic proportions. Intensive surveillance is being maintained through test-of-cure and recheck programs for immediate detection and treatment of this disease strain.

With the increased incidence of genital herpes, non-gonoccocal urethritis, and other infections that are not yet required to be reported, the term *venereal diseases* is being replaced by *sexually-transmitted diseases*, a more specific designation.

Communicable Disease Control Program—This program makes use of morbidity and mortality reports on selected reportable communicable diseases that are collected through personnel in the department's regional offices or in local health departments. Reports of field investigations of outbreaks and individual cases, identification of infectious agents by laboratories, and other relevant epidemiological data are collected, tabulated, analyzed and used to guide, improve, and evaluate control measures. Consultation is provided to local and regional health departments, private physicians, hospitals, other institutions, and veterinarians regarding the diagnosis, treatment, protection, isolation, or quarantine of persons infected with, or having contact with, individuals or animals with communicable diseases.

While the overall number of reported cases of communicable disease, including animal bites, has remained at approximately 70,000 annually, specific disease incidence reveals changes when the 1961 and 1976 data are compared. The number of human brucellosis cases reported in 1976 was only approximately 10 percent of that number reported in 1961. Likewise, the present incidence of rheumatic fever has been reduced to one-fourth that of

the early 1960s. On the other hand, significant increases have been noted in the incidence of salmonellosis cases (other than typhoid fever) and hepatitis B (serum hepatitis).

Three outbreaks of Saint Louis encephalitis were reported between 1961 and 1977. Outbreaks in 1964 and 1966 clustered in southern Illinois (Hamilton and Saline Counties) where twenty-two and thirty-three cases respectively were reported. A statewide epidemic of Saint Louis encephalitis occurred in 1975, and 578 cases of this mosquito-transmitted disease were reported. As a result of the 1975 episode, an early warning arbovirus surveillance program was established in the department.

Communicable disease control program staff coordinated activities for the investigation of a large outbreak of gastrointestinal disturbance in groups that visited the Pere Marquette State Park in May, 1972. Over 600 individuals were interviewed during the investigation—96 had become ill. Examination of stool and water samples collected in connection with the outbreak failed to reveal any specific pathogenic organisms. It appeared that the ill individuals who drank from a contaminated well in the park were victims of "sewage intoxication." The contaminated well was closed.

Program staff answered a request for aid from the Cook County Department of Public Health in September, 1974, to aid in the investigation of an outbreak of food-borne illness potentially involving 1,200 individuals. Investigation revealed all ill individuals had consumed food prepared by a catering establishment in Cook County. The causative agent was documented and corrective actions were initiated.

An annual influenza surveillance program was established in the communicable disease control program in 1974. Activities include the collection of data from sentinel physicians, hospital emergency rooms, schools, and laboratories. Cases of influenza-like illness and school absenteeism are reported, as are serologic and culture results from laboratory examinations. The purpose of this program is to collect and report accurate data to health care providers and the public regarding current influenza activity. Additionally, laboratory studies of virus isolates provide information regarding changes in the virus' characteristics.

One epidemiologist was added to the central office staff in 1972 and three regional communicable disease epidemiologists were added to the staff in 1974. The regional staff expanded by two in 1975 with expectations that ultimately a communicable disease epidemiologist would be assigned to each department regional office. These individuals are engaged in the surveillance of report-

able communicable diseases, including the reporting, investigation and initiation of control measures.

The New Jersey Swine-Like Influenza Immunization Program— The President of the United States, Gerald Ford, instituted this program nationally in 1976, subsequent to cases of disease due to a markedly different influenza virus, in an eastern military establishment. Such changes in the virus seen in earlier decades were always followed by severe pandemics. As a result, the so-called swine flu immunization program was inaugurated and partially federally financed. The program in Illinois started delivering immunizations on October 15, 1976 and continued until December 16, 1976, when a significant association with a temporary paralytic disorder prompted a two-month interruption. During the two-month period of immunizations, 1,481,723 people were immunized. Some 954,664 received protective immunization against "swine flu" only, and 527,059 "high risk" Illinoisans were immunized against "swine flu" and A/Victoria influenza. In previous years, it was estimated that about 10 percent of the high-risk persons (generally those over 65 and/or those with respiratory ailments) received influenza vaccine. Approximately 40 percent of the high-risk population were immunized during this program, more than twice as many as had ever been immunized before against influenza.

There were many additional benefits of the program. Hundreds of health workers were trained in the use of the jet-injector gun. This expertise is very valuable in the ongoing immunization effort throughout the state. Better communication systems were established between health-related agencies, as well as government and volunteer agencies. Many people became more aware of the process of immunization and the importance of immunization. Finally, it was proved that it is possible to quickly establish an immunization system that is capable of delivering protective immunizations to the entire population if necessary.

The program itself was severely criticized by various health and other governmental agencies and individuals from its inception. The logistics in establishing local and community immunization efforts and providing the needed supplies was a problem of major proportions. The brevity of the immunization period left the department with large amounts of unused supplies in storage. From a purely financial standpoint, the program was extremely costly. From a public health standpoint, only the number of immunizations administered can be used to evaluate the program as "successful." Here again, as in most cases, the value of public health efforts must be

judged on the basis of what doesn't occur. The reason why Illinois, as the rest of the nation, had one of the mildest "influenza seasons" in history remains undetermined.

Immunization Program—In existence since the availability of smallpox vaccine, this program contributed substantially to the health of the people of Illinois from 1961 to 1977.

Field trials with Salk polio vaccine were conducted in Illinois in 1955, and distribution of polio vaccine began in 1956. Live polio vaccine (monovalent) was made available in May, 1962, and distributed free in Illinois. The decrease in incidence after that date was dramatic, dropping from 65 cases in 1962 to none in 1972, and with none reported through 1977.

In June, 1964, live measles vaccine was made available through the department for immunization clinics for well-baby, preschool, kindergarten, and first grade age groups. The reported number of measles cases in 1961 was 16,931 as compared to 2,385 in 1976. The distribution of rubella vaccine began in September, 1969. Almost 1,000,000 doses were purchased and distributed from the state appropriation for medical preparations before June 30, 1970. Mass communitywide rubella clinics were promoted, and assistance was rendered by the personnel of the immunization program.

Measles/rubella vaccine was purchased with Illinois State Immunization Project funds in October, 1971, and made available to health departments only for their use in clinics. Measles/rubella vaccine was made available on March 30, 1973, to physicians.

In 1974, mumps vaccine was included for the first time in the immunization program. From 1974 to 1977, over 79,000 doses of this immunizing agent were distributed throughout the state.

Also in 1974, the program was further expanded to include the distribution of influenza vaccine to high-risk groups—those over 65 years of age and those suffering from such chronic illnesses as heart disease or diabetes or diseases affecting the lungs or kidneys. In 1975, 50,000 doses of the vaccine were distributed. This number reached 65,000 in 1975.

Measles/mumps/rubella vaccine was made available in February, 1975 for use by public health facilities. This provides protection against all three diseases with a single injection.

Lead Poisoning Program—A statewide survey of lead poisoning was conducted in 1971 in cities with populations ranging from 10,000 to 150,000. Prior to this, labeling standards were established for any lead content in any paint accessible to children. In January, 1971, the president signed the "Lead-Based Paint Poisoning Preven-

tion Act" into law. Hence, the Division of Disease Control began developing program activities that would identify the incidence of lead poisoning and increased lead absorption.

The "Lead Poisoning Prevention Act" (PA 78–560) was signed into law in Illinois on September 6, 1973. It made lead poisoning and elevated blood-lead levels (40 micrograms percent or greater) reportable, prohibited the use of lead-bearing paint in dwellings, gave the department the authority to inspect dwellings for lead-bearing substance, and required owners of such dwellings to eliminate the hazard. Program objectives were to identify children at high risk of developing asymptomatic lead poisoning or its sequela (mental retardation) by blood-lead analysis, and to prevent further exposure by causing removal of the lead hazard from the child's environment. For children, the source of lead was usually lead-based paint, applied to the surface of their homes. The surveillance reporting system became operational January 2, 1974.

In 1975, the department received a $14,900 grant from the Public Health Trust, Attorney General of Illinois, to purchase three portable lead analyzers for use in surveying buildings and homes to determine whether or not lead-based paint was present. Through a cooperative effort involving the Division of General Sanitation, the Division of Education and Information and area workers, screening programs were begun to be conducted throughout the state. Screening programs have been conducted also at selected sites each summer in cooperation with the Illinois Association for Retarded Citizens. The Division of Public Health Laboratories has been involved in the performance of blood-level analyses and the analysis of paint chips. A manual, *Lead Poisoning: Case Detection, Medical Evaluation and Environmental Methods in Pediatric Lead Poisoning*, was written, published, and distributed by the department to Illinois health agencies. This program has brought about many improvements in the manufacture of paint; in the removal of lead sources available to children, especially in the housing of deprived families; and in the detection and treatment of children suffering from lead ingestion.

Renal Disease Program—The renal disease program, as a departmental function, was the direct result of Doctor Yoder's vision and foresight. After innumerable telephone calls to his office from beleaguered parents and relatives of renal disease victims, it became apparent that facilities for treatment were in short supply and that the cost of treatment in the available facilities was far beyond the means of other than affluent individuals. Although adverse opinions were expressed by many respected professionals in public health, claiming that such a program was not preventive in character,

Doctor Yoder went ahead on the principle that the saving of life pre-empted every other consideration. At his direction, legislation was prepared and introduced with the governor's approval into the general assembly. At various hearings in both houses, victims of renal diseases testified and so impressed the members of the 75th General Assembly that House Bill 611 appropriating one million dollars to the department for a renal disease program passed without a dissenting vote. It was approved by the governor on August 18, 1967. An eleven-person advisory committee and the qualifications of the members were mandated by the statute.

Among the initial efforts of the department was a survey of all general hospitals in the state (263), which revealed that only eleven had ongoing renal dialysis programs. Also developed and distributed was the pamphlet, *Guidelines for Hospital Participation and Medical Criteria for Patient Acceptance*. The first dialysis patient under the department's program of subsidizing payment for care and treatment was accepted on March 15, 1968. Since that time, approximately 3,300 applications for assistance have been received.

During the life of this program, the advisory committee has recommended essential changes as experience developed. These have included the removal of age limits, leaving the medical condition as the basis for referral. Guidelines for limited care facilities (satellites) were developed in 1970 when it became evident that out-of-hospital care should be provided along with home dialysis.

On July 1, 1973, Medicare became involved in the renal failure (end stage renal disease) program, establishing an organized network system with regulations and fee schedules. The Department of Public Aid worked closely with the Department of Public Health in the administration of the program, the latter making all medical approvals for both departments.

Hemophilia Program—This program was established in 1974 to assist hemophilia patients with financial aid for quality care. It was originally assigned to the Office of Health Facilities and carried a line item appropriation in the department budget. During the first year of its operation, the program registered approximately 300 patients. About 100 patients received assistance in fiscal year 1975. The program was then transferred to the Office of Health Services toward the end of that fiscal year.

This program has been operated in cooperation with the Division of Services for Crippled Children (University of Illinois), an organization providing medical care for children. The department assumed responsibility for providing the missing coagulation factors from the

blood for all patients, as well as out-patient care for adult hemophiliacs.

In early 1977, there were nearly 400 of the possible 775 patients in the state registered with the program. This program is aimed primarily at those who cannot afford treatment, which may cost as much as $10,000 a year. A statute mandating the program and creating an advisory board was enacted in 1977.

Cancer Control—A division of cancer control was first created in the department in 1939. In 1961, the Illinois death rate from cancer was 168.2 per 100,000 population, ranking second only to heart disease as a killer of Illinois residents.

By 1961, cancer control activities were vested in the Bureau of Chronic Illness. The principal aim of the cancer control program was the early detection of the disease. Public education (especially regarding early symptoms) and the promotion of cervical cytology programs by local health departments, hospitals, and institutions were the main activities. The latter activity was one of support for local health department screening programs for cervical cancer through payment to physicians for Papanicolaou (Pap) smears for people unable to pay for such examinations.

The so-called East Side Cervical Cytology Study was completed in fiscal year 1962. This study was designed to test methods of getting indigent and recipient females to accept Pap smears for the early detection of cervical cancer. Of five different methods used, the most effective proved to be physician referral. During the period of the study (May 5, 1960 to April 1, 1962), 1,382 females were screened. Of this number, 2.8 percent were classified as positive or suspicious and required follow-up.

In fiscal year 1964, a large portion of the funds allocated for cancer control were spent by the department in support of special local demonstration programs. The Chicago Board of Health was partially supported in a program for the early detection of cancer through the use of exfoliative cytology. Coupled with this was an extensive educational program conducted by public health nurses for patients.

A second project supported that year was entitled "Gastrointestinal Cancer Detection by Newer Exfoliative Cytology Methods." This was based at the University of Chicago and was essentially a training program for physicians and technicians.

In fiscal year 1965, another study was undertaken in cooperation with the Illinois Bell Telephone Company. This involved both the Pap smear and do-it-yourself irrigation smear.

In fiscal year 1968, in addition to Chicago, the following city and

county health departments had established Pap test programs: the East Side Health District, Morgan County, Cook County, Jackson County, Quadri-County, Peoria County, and Evanston. In that year, Chicago reported 29,616 Pap tests, and the other areas, a total of 5,572.

Subsequent years showed some increase in testing, due primarily to the development of family planning clinics.

The department actively supported the passage in 1973 of the Illinois Pap Test Law that required hospitals to offer a cervical cancer test to all female patients age twenty and over. This legislation was designed to make certain that a woman admitted to an Illinois hospital, for any type of illness or injury, would not be discharged with undetected cervical cancer.

The cervical cancer detection program had reached a plateau in terms of the number of tests performed and the number of agencies interested in initiating such a program. Records of the Lashof administration indicate the obtaining of a federal contract for a cervical cancer screening program. The program was aimed at reaching an estimated 58,000 women in Illinois who had not had a Papanicolaou test. It was also estimated that more than five percent of these women would be afflicted with undetected cervical cancer. The program was designed to work through local health agencies to detect cancer and to assist in getting treatment. Still a long way from reaching the targeted numbers, it continues to date.

Also supported that year was a project in cooperation with Augustana College to determine smoking habits among junior and senior high school students in Rock Island County, with a ninth grade follow-up study after an in-school education program centering on the effect of cigarette smoking on the incidence of lung cancer.

Diabetes—Even before 1961, the department was concerned with diabetes. Its main effort was toward education concerning the disease and in finding undetected cases. In fiscal year 1962, a diabetes detection screening program was carried out in Adams and Macon Counties. During 1962, with funds made available by the department, an extensive multiphasic screening project (then a rather new approach and considered a major breakthrough in casefinding techniques) was undertaken in cooperation with the Chicago Board of Health. The major focus in this demonstration project was the early detection of chronic diseases, diabetes included, in persons thirty and over and residing in selected public housing projects in Chicago.

Here again, the department's main effort in the detection of this

chronic illness was through financial support of screening programs established by local health departments. By fiscal year 1965, five county health departments and Chicago were conducting diabetes screening projects, either as special programs or as a part of a multiphasic screening program. In some instances, diabetes screening was broadened to become multiphasic in character.

During fiscal year 1968, local health departments conducting diabetes screening programs were the Chicago Board of Health, Adams County, Quadri-County, Egyptian, Franklin–Williamson County, Peoria County, and Stickney Township. These agencies accounted for 32,859 persons screened and 893 positive tests in that year. To these agencies was added the Lee County Health Department in July, 1968.

In order to provide more information to the private physician and to minimize over-referrals, each individual found to be positive by the capillary blood test was asked to return to the clinics for a glucose loading test. Again, in fiscal year 1969, 39,057 individuals were tested and 1,117 new diabetics discovered.

In fiscal year 1970, the Skokie Health Department began a diabetes screening program, bringing the total to eleven local health departments in seventeen counties or cities. Together that year, they screened 40,738 individuals and made 1,398 referrals to private physicians.

By the next year, fiscal 1971, fifteen local agencies were conducting screening programs. In recent years the number of projects being conducted have remained about the same and the number of persons screened annually has averaged around 40,000. Late in 1977, the department received a federal contract with the Center for Disease Control to plan a program of improved care for diabetics.

Rheumatic Fever—The prevention of rheumatic fever, a disease primarily of children, was beginning to receive major emphasis on a national level in 1961, although it had been subjected to study in Illinois for several years. As a result of several years of preparation, the Chicago Board of Health embarked on a program in 1961 to promote routine culturing for group A beta hemolytic streptococci as a widespread practice. Arrangements were made in Chicago for processing cultures at the Board of Health facilities for those unable to pay. At that time, culturing was available through commercial and hospital laboratories to those able to pay two dollars per culture. In 1962, the Chicago Board of Health processed 6,140 throat cultures, finding 708 (11.5 percent) that were positive for group A beta hemolytic streptococci.

Although the laboratories of the department also processed the

cultures of those unable to pay in downstate Illinois, emphasis was placed on the greater utilization of private facilities. In addition to the usual culture methods, the fluorescent antibody technique was employed in the department's laboratories.

At that time, the prevention of secondary attacks of rheumatic fever was the basic heart disease control activity of the department. The program consisted of maintenance of a registry of patients (those having positive cultures and referred to private physicians), provision of prophylactic medication (usually a form of penicillin) free of charge to physicians, and utilization of a follow-up system to insure patients were maintaining their treatment schedules.

As of June 30, 1963, in the downstate area, there were about 9,500 patients registered, most of whom received prophylactic medication. The delinquency rate was about 25 percent.

Although the program of the Chicago Board of Health was a separate operational entity, the department supplied the prophylactic medication for free distribution by the Board of Health. Also, the Chicago program reported periodically, thereby supplying pertinent information for the central registry maintained by the department. By the end of 1964, the active cases on the central registry (including Chicago) numbered 13,273.

In 1963, a dentist-operated throat culture program was started in Stickney Township to determine the practicability of utilizing dentists in the detection of the organism that triggers rheumatic fever. It was reasoned that, since dentists saw a substantial number of children in the community at one time or another, it would be possible for them to take a throat swab, have it cultured and notify the family physician of results. After almost three years, the Stickney project came to an end and was considered a successful demonstration of how to obtain throat cultures for rheumatic fever. The study was accepted by the American Dental Society and published in its nationwide journal.

In fiscal year 1969, there were some 14,000 persons receiving prophylactic drugs. For two years prior to that and during fiscal year 1969, there was a downward trend in the number of new admissions to the program, which dropped below 1,000 per year for downstate Illinois.

By the end of fiscal year 1972, the rheumatic fever program was transferred to the Division of Family Health from the Division of Chronic Illness, the latter being phased out as a separate organizational unit. Then in fiscal year 1973, rheumatic fever follow-up and medication distribution responsibilities were transferred to local health departments, although the overall administration of the

program was continued by the Division of Family Health. During that year, approximately 8,000 patients downstate and 6,000 in Chicago received a total of 52,535 bottles of medication.

The program continues into 1977 on the same basis and to approximately the same extent as indicated above.

Cardiovascular Diseases—The department programs to prevent or control the cardiovascular diseases have been rather numerous. The effort and funds expended have been substantial. Mortality, due to cardiovascular diseases, has declined with the multifaceted attack on the problem in all phases of health care. Much remains to be done, however, and the roles of the many programs involved have been difficult to evaluate. The rheumatic fever program, whose objective has been to prevent the subsequent incidence of rheumatic heart disease, must be considered as one of the more effective programs in this total effort.

The Heart Sounds Screening Program in Chicago schools in 1959 and 1960, financed in large part by the department, screened some 300,000 elementary school children and uncovered 33 new cases of heart disease.

In fiscal year 1963, the Coronary Prevention Program of the Chicago Board of Health was engaged in field trials to test the possibility of achieving primary prevention of coronary heart disease. This trial involved a group of middle-aged men and the correction of such abnormalities as overweight, hypercholesterolemia, heavy cigarette smoking, and inactivity to determine the effect on the coronary heart disease picture.

In 1963, a program was initiated in Peoria to assist the practicing physician in the management of patients with congestive heart disease. This program utilized the public health nurse to visit patients to insure that they remained on the physician-prescribed regimen of drugs, diet, and rest. Concurrently, a registry of patients was established in which cardiac status, recurrences, and progress were recorded.

In 1965, the department added a few new activities to its heart disease control program. These included the promotion of programs on closed chest resuscitation, establishment of coronary intensive care units, and support of a stroke coordination project.

In fiscal 1967, Loyola University School of Nursing conducted a number of three-week workshops on the nurse's role in intensive coronary care in hospitals. These workshops, sponsored and financed by the department, terminated July 1, 1969.

Rehabilitation nursing techniques, including the care of coronary

patients, were taught at the rehabilitation institutes conducted in Chicago and Peoria under department sponsorship and financial support.

Hypertension (high blood pressure) has for many years been a major public health concern. In the years before 1974, the department efforts with regard to hypertension consisted mainly of education of the public and the promotion of testing in available local clinics and in multiphasic screening projects. By 1974, it was determined that one out of seven Americans was affected by high blood pressure. In that year, the department implemented a Hypertension Screening and Surveillance Program in an effort to reach the estimated one million hypertensives in the state and to place those discovered under medical supervision.

The program involved (1) casefinding by local health departments; (2) the systematic entry of appropriate medical information in the hypertension registry of the department; and (3) education of the public concerning the dangers of hypertension and the importance of its diagnosis and control. In December of 1976, the department made available to ten local agencies $148,483 for programs to control hypertension. In 1977, $300,000 was made available to thirteen health agencies.

Black Lung Disease—In 1975, the first federally funded clinic for the comprehensive care of Illinois coal miners was opened. The clinic, located at Herrin, serves southern Illinois coal miners suffering from black lung and other chronic respiratory diseases. More than 8,000 of the state's 11,000 active coal miners are employed in southern Illinois.

By 1977, additional clinics were opened at West Frankfort, Litchfield, Taylorville, and Canton, utilizing a $300,000 grant from the National Institute for Occupational Safety and Health of the U.S. Department of Health, Education, and Welfare. These serve about 600 coal miners annually.

In the 1977 Spring session of the general assembly, a bill was introduced to impose a five percent coal severance tax on coal sold for use outside of the state. A portion of the revenue realized was to be used for black lung disease centers.

Although the bill passed the general assembly, it was vetoed by the governor in September, 1977. On July 1, 1977, the United Mine Workers Health and Retirement Fund announced a reduction from 100 to 60 percent of the medical costs of miners. These actions severely threatened the future of the five clinics, leaving the department to search for adequate funds for continued operation.

Commentary

A number of other programs and activities, although related in some way to this section, have been discussed in either Chapter 8 or 11.

Chapter 5

FAMILY HEALTH

The programs discussed under this heading are primarily those relating to women, infants, and children. The unit responsible for these programs has been known as Child Hygiene, Maternal and Child Health, and Family Health.

When Doctor Yoder came to the directorship, the unit was known as the Bureau of Maternal and Child Health in the Division of Preventive Medicine. The reorganization of 1970 resulted in changing the name to the Division of Family Health in the Bureau of Personal and Community Health. This name remained the same during the Lashof administration, although the name of the bureau under which it operated was changed to the Office of Health Services and Local Health Administration. The title continued to be the Division of Family Health under Doctor Peterson.

Prior to 1961 and up to January 25, 1967, Donaldson F. Rawlings, M.D., M.P.H., served both as chief of the Division of Preventive Medicine and chief of the Bureau of Maternal and Child Health. On that date, James P. Paulissen, M.D., M.P.H., was appointed as chief of the bureau. Subsequent to his resignation on February 29, 1976, Patricia Hunt, M.D. was appointed to the position on August 16, 1976.

Perinatal Program—The availability of care for newborn infants became a concern of the department in the 1940s. With the development of chemotherapeutic and antibiotic agents, the problems in infant mortality shifted from infectious diseases as the primary cause of death to causes relating to the birth process. One of the major contributing factors to infant death has been prematurity, defined at the beginning of the program as a birth wherein the infant weighed five-and-one-half pounds or less. This weight was subsequently reduced to four-and-one-half pounds and then to four pounds.

The department established its first program for the care of premature infants in 1943. As developed at that time, the program was intended to establish premature care centers in selected hospitals to provide care not available in many hospital nursery services. Initially, two centers were established in downstate Illinois in 1943 and a third was added in 1948 (Springfield, Peoria, East St. Louis). Simultaneously, the Chicago Board of Health had developed centers at three hospitals in that city; in 1956, the two programs were merged.

The success of these centers, subsidized generously by the department, in coping with the problem of prematurity led to the possibility of providing intensive care for newborn infants beyond the usual care for prematures.

In 1968, St. John's Hospital in Springfield indicated a willingness to participate in a pilot program of expanded services to the newborn. A fifty-mile radius was chosen as the geographic boundary, and the Springfield center began to receive infants from eleven counties within that radius in January of 1969. The success of this pilot program in the care of high-risk infants led to the provision of such services to the entire service area of St. John's Hospital and most of the service area of St. Francis Hospital in Peoria by the end of 1970.

In order to encourage the use of these centers for infants most in need of care, the routine admission weight was lowered to four pounds for prematures (formerly four and one-half pounds or less), and infants over four pounds would not be admitted merely on the basis of prematurity. The latter were admitted if there were any complications making special care desirable. The desirability of this change is demonstrated by the shifting pattern of admissions.

Late in 1973, statistics indicated that nearly 60 percent of the babies admitted to the centers were classified as "high-risk" infants while the remainder were admitted for prematurity only.

The impact of this program cannot be judged by numbers alone, although admission figures do give some idea of its extent. The following listing shows 11 fiscal years and the number of admissions each year to the six centers:

1962.....1,516
1963.....1,522
1964.....1,596
1965.....1,627
1966.....1,604
1967.....1,592
1968.....1,523
1969.....1,601

1970.....1,638
1971.....1,951
1972.....1,932

An average of about 10 percent of the prematures in Illinois were cared for in the specially established hospital centers.

In order to reduce the time and other hazards in getting a baby to the nearest center, a well-equipped department ambulance was on twenty-four-hour duty with a driver and a nurse in attendance. Another facet of the program was follow-up visits by a public health nurse to the home of any infant discharged from one of the centers. These visits enabled the nurse to determine conditions within the home; to provide nursing care, advice, and nutrition information; and to determine the progress of the baby. To upgrade nursery services, nurses from other hospitals were sent, at department expense, for training at each of the centers.

Late in the Yoder administration, planning was begun to expand this program to a statewide basis. Actual implementation of a plan for perinatal regionalization took place during the Lashof administration. In order to evaluate the program as it existed and to determine how the program should be modified, the department sought the assistance of the newly-formed Illinois Committee for Perinatal Health, made up of neonatologists, pediatricians and obstetricians.

Shortly thereafter, the general assembly created a committee to study the needs and problems associated with individuals who were developmentally disabled. In the course of hearings held by this committee, the need for an organized system of perinatal care evolved. Legislation drafted by that committee (H.B.725) was entitled "An Act Relating to the Prevention of Developmental Disabilities." Passed by both houses of the general assembly, it was approved by the governor in September, 1973, becoming Public Act 78–557.

Under the terms of the act, the department was made responsible for developing a regional perinatal program leading to the prevention of developmental disabilities.

The Illinois Committee for Perinatal Health, continuing its interest and efforts, approached the State Comprehensive Health Planning Agency with a plan to be offered to the department for implementation. The planning agency agreed to cooperate in support of the planning effort. Representatives of nursing and hospital administration were added to the Committee for Perinatal Health, and the Rockford School of Medicine agreed to offer logistical support for committee activities.

These agencies and the department began work early in 1973 on the basis that the program would be designed to reduce both maternal and perinatal mortality rates by providing intensive and highly specialized care (not available in all hospitals) for women and newborn infants at high risk prior to, during, or following delivery.

The legislation enacted required the department to develop standards for all levels of hospital perinatal care, as well as for perinatal centers. Required of the latter were standards relating to trained personnel: full-time twenty-four-hours a day X-ray and laboratory facilities; infant monitoring equipment; transportation for mothers and infants; genetic services; surgical services; cardiology; and other consultation and support services as deemed necessary. The statute required further that the standards, when developed, would be disseminated to all hospitals so that those interested in being designated as perinatal centers could notify the department of their intention and ability to meet the standards.

Another requirement was that the department, in consultation with local health planning agencies, would develop a regional plan with designated perinatal centers in each region of the state. The following were also made mandatory: (1) a department analysis of the adequacy of transportation systems; (2) development of guidelines for infant transport to perinatal centers; (3) establishment of guidelines for local and areawide programs designed to prevent high-risk pregnancies through early identification, screening, management, and follow-up of childbearing-age, high-risk females; (4) development of criteria for identification of high-risk mothers, such criteria to be circulated to physicians, hospital administrators, and health officers; and (5) notification of each physician of the facilities designated as regional perinatal centers.

The bulk of these requirements was referred to the Illinois Committee for Perinatal Care, which, in turn, set up separate expert subcommittees on each subject.

The standards were finalized and sent to all hospitals having maternity services in October, 1973. Then began the implementation period wherein a highly sophisticated and complex program had to be organized. Many factors had to be satisfied, and many professionals and community leaders had to be convinced of the value and practicability of the program, especially with regard to the establishment of centers and the boundaries of regions. On the basis that a center should have 450 to 500 admissions a year, it was determined that a region should produce 15,000 to 17,000 live births a year. Past experience with the three downstate premature infant centers also gave some insight into referral patterns.

In the fall of 1974, the department began working out agreements with university medical schools to use the medical schools' primary teaching hospitals, and, in some cases, an affiliate hospital as the site of service.

From then up to 1977, eleven perinatal centers were established and work continues to establish additional ones.

Grants in the amount of some $39,000 per year were awarded to each center. The program also paid costs for about 4,000 cases per year where the family did not have the ability to pay and was not covered by third-party payers. The management of high-risk pregnancy and care of the newborn child cost less than $2,500 as compared with $250,000 for lifetime care in an institution for one mentally retarded person.

The department administers this program, coordinating resources, setting standards for participation, and providing financial assistance. High hopes are held for the substantial reduction of maternal and infant mortality as well as developmental disabilities. Provisional statistics already indicate such a trend.

Phenylketonuria—Phenylketonuria (PKU) is a heritable metabolic disease of the newborn that, if undiagnosed and consequently untreated, results in mental retardation.

The PKU program, initiated in 1958, went through several phases in its development. The first year was devoted to educational programs, counseling services, and case-finding activities. A booklet entitled *Information for Hospital Personnel Regarding the Problems of Phenylketonuria* was prepared and distributed to every hospital in the state. In 1961, the department began providing the treatment product, Lofenalac®, for diagnosed cases at no cost to the families involved.

The first PKU screening bill, "An Act Concerning the Voluntary Testing of Newborn Infants," was enacted in August, 1963, and carried an appropriation of $50,000. This legislation made the department responsible for implementing a program of educating, screening, diagnostic testing, maintaining a registry of cases, providing necessary treatment products, and establishing an advisory committee with a designated membership.

The department's first concern was the establishment of laboratories qualified to perform PKU screening tests on blood samples. In August, 1964, with the cooperation of the Illinois Hospital Association, a survey was made of the laboratory facilities of every hospital in the state. This study revealed that approximately 40 percent of all hospital laboratories were doing their own routine blood screening tests for phenylketonuria. The others were using either state or

private laboratories for testing, or were not routinely testing all newborns.

In April, 1965, a bill was signed into law making PKU testing mandatory for all newborn infants in Illinois. The department was charged with responsibility for promulgating and enforcing rules and regulations to implement the program. In 1965, a metabolic disease section was established in the Bureau of Maternal and Child Health. By April, 1966, officially approved rules and regulations had been distributed to all hospitals, physicians, public health agencies, and other interested groups and individuals in the state.

By this time, also, the department's Division of Laboratories had instituted a procedure for certification of qualified laboratories. In addition, the department's Chicago laboratory and two of its downstate laboratories were performing screening tests for those hospitals whose laboratories were not equipped for PKU testing. In July, 1970, however, the department's laboratories discontinued the processing of routine screening tests for hospitals although continuing the laboratory certification procedure.

Between 1966 and 1971, over 90 percent of all newborn infants in Illinois received blood screening tests of PKU within the first few days of life. The percentage not tested were infants who died within twenty-four hours after birth, who were too ill or too premature to be tested immediately after birth, or who were moved out of state before they could be tested.

A registry of newborn infants with PKU positive tests has been maintained since 1961, thereby preceding either the voluntary testing statute or the mandatory testing statute. The total number of cases registered from 1961 to 1972 was approximately 175. Each of these continues to be monitored by the department.

Of all the information gathered, the educational progress of the patient was considered to be a practical overall estimate of the child's level of function. The child's educational classification was ascertained since this is generally considered the measure of functional achievement in children. The progress of ninety children registered between 1961 and 1965 was studied in 1971 because these children were by then of chronological school age. This study seemed to confirm the findings of other studies that showed the earlier treatment was instituted, the better the chance for increased educability and mental progress.

Of the ninety children studied, twenty-six were able to attend regular school; twenty-five were considered "educable"; twelve were considered "trainable"; and fourteen suffered severe retardation. Of the twenty-six children able to attend regular school,

twenty-four had been placed on dietary therapy between the time of birth and three months of age. The others received therapy at a later period in their infancy.

The incidence of PKU cases in Illinois, while varying substantially from year to year, has averaged one for each 17,598 births.

This program was continued throughout the Lashof administration with approximately the same results obtained and the same expenditure of effort as reported above.

As with other public health programs, this one has not only benefited individuals (the first consideration), but has been economically profitable to the taxpayer by reducing the cost to parents and the state for the extra care of the mentally retarded.

Family Planning—In 1969, the Social Security Act was amended by congress authorizing an appropriation to states for financing programs in family planning. The amended act also provided that, in order for a state to be entitled to a general maternal and child health federal grant, its MCH plan must provide for the development of demonstration services "with special attention to family planning services to mothers." The department, therefore, necessarily accepted family planning as a function rather than jeopardize the federal Childrens' Bureau formula grant for all maternal and child health programs. Federal regulations further stipulated that progress toward making family planning services available to mothers in all parts of the state *must* be shown by 1975 in order to continue to qualify for general maternal and child health funds.

The department's first step was the development of a policy statement on family planning that was submitted to, and approved by, the Maternal Welfare Committee of the Illinois State Medical Society. At the time, family planning was not well understood by, or acceptable to, a substantial segment of the population. For these reasons, the department labored long and diligently to produce a statement devoid of ambiguity or false pacification. That statement follows.

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

Policy Statement on Family Planning

The Illinois Department of Public Health supports family planning as a plan of action by which individual families attempt to develop their full potential for physical, mental and social well-being, in the interest of better public and personal health. It should not be limited to the spacing of children but should also include a concept of services to those couples who seek to correct their infertility in order to have a family. These services should be available not only as a part

of the postpartum clinic services but as a part of maternity services which women could use at times other than during the maternity cycle.

From the health standpoint family planning in relation to family size is important. Wanted children are essential to total family health while unwanted children frequently have an adverse effect in that family size exceeds family means for such things as adequate housing, food, clothing and education. Unwanted pregnancies also often cause women to seek illegal abortion with subsequent devastating effect on the individual health as well as family life and health.

It is the position of the Illinois Department of Public Health that assistance in family planning should be made available to all who wish it in accordance with their individual desires and beliefs. The department further believes that such assistance should be provided only by physicians or through programs conducted with support of physicians and should always preserve the individual's acceptance of the methods used. This department will give consultation and cooperate with local health agencies as well as private health agencies, in public and professional educational services relative to family planning and support medical programs and referral services for those groups which would not otherwise be able to avail themselves of professional services by private practitioners.

Responsibility for the program was assigned to the Bureau of Maternal and Child Health, which proceeded on the basis that family planning would be available as a part of total maternal care.

On June 25, 1969, a memorandum was sent to all local health agencies advising them of the availability of funds for family planning programs together with a guide for developing local programs and an offer of consultive services. One of the requirements involved in obtaining a grant was the contribution of local funds and/or services in the amount of 25 percent of the local family planning budget. Grant applications were screened by the department's Program Review Committee (as were all other local applications for grants) and by the Family Planning Review Committee made up of professionals in the Bureau of Maternal and Child Health.

In conjunction with the allocation of grants, a reporting system was initiated in order to determine that the services described in the application were being delivered.

Among the first to receive a grant was the Peoria City Health Department (Project 763), which contracted with the Planned Parenthood Association of Peoria.

Likewise, family planning services were provided in Chicago by the Chicago Board of Health (Project 502). In fiscal year 1971, however, the Family Planning Coordinating Council of Metropolitan

Chicago, Inc., became the recipient of project funds (Project 712) replacing the Chicago Board of Health. This transfer was effected through the new deputy director of the department for reasons never made clear.

Also in fiscal year 1971, sixteen additional grants were awarded to local health agencies. The same number were awarded in fiscal year 1972, amounting to $402,490. Then, in fiscal year 1973 (the year in which Doctor Yoder was succeeded by Doctor Lashof in February), the Division of Family Health (formerly the Division of Maternal and Child Health) contracted with the Illinois Family Planning Coordinating Council for the funding of ten additional downstate local health agencies in the amount of $235,000.

In 1975, the Cook County Department of Public Health and the Winnebago County Health Department established family planning programs with financial assistance from the department.

The Illinois Family Planning Coordinating Council continued to provide direction and supervision to local programs until June 30, 1977. On that date, the department began to provide needed consultation in obstetrics, pediatrics, nutrition, and nursing to the existing local family planning programs.

In fiscal year 1977, the department financed these programs to the extent of 1.13 million dollars.

Supplemental Food Program—This program is known in full as the "Supplemental Food Program for Women, Infants, and Children," and is commonly called the "WIC" Program. This activity, funded by the U.S. Department of Agriculture, began operation in Illinois in February, 1974, to become the department's first major nutrition effort in many years. This program has provided: (1) semiannual health assessments; (2) nutrition counseling; and (3) a monthly high-nutrient food package to low-income, pregnant or lactating women, to infants, and children to age five, who are determined professionally to be at nutritional risk.

The WIC Program was started in 1974 with four centers and 10,000 mothers and infants enrolled.

Although the program has been administered by the department, all direct services, including special health services, have been provided by local health agencies.

In the first three-and one-half years of existence, it grew from four to 20 local projects serving more than 38,000 clients. WIC services are often provided in existing maternal and child health clinics, and many Medichek patients receive these services.

Sudden Infant Death Syndrome—A rash of sudden, unexplainable infant deaths in the state, noted especially in Chicago, led to the

passage by the general assembly of the act to create the Sudden Infant Death Syndrome Study Commission. This legislation was approved by the governor on August 2, 1972. It stipulated that the commission was to report its findings to the general assembly no later than March 15, 1973; it appropriated $9,000; and it set the date of repeal as July 1, 1975.

Available records fail to reveal the contents or results of the study.

It is estimated that each year in the United States, approximately 10,000 infants die of this mysterious condition. Without knowledge of a cause or methods of prevention, public health turned to the only available activity—training programs for physicians, nurses, coroners, social workers, police officers, clergymen, funeral directors, and others who could be instrumental in helping parents deal with the problem.

It appears at this time that the problem is primarily one of research beyond the financial capabilities of public health. Surveillance and the centralization of a medical information registry appear, however, to be possible activities that would assist the research efforts.

Vision and Hearing Program—The department's Vision and Hearing Program has had a long and productive development period. The vision component began as many public health programs do, under the aegis of a voluntary agency—the Illinois Society for the Prevention of Blindness. The society sponsored vision screening programs during the 1930s, employing WPA workers who screened more than two million persons. The vision status of children received added attention during the 1940s and 1950s, with several groups (ophthalmologists, optometrists, nurses, school officials, and others) attempting to identify eye problems among children. This activity by various groups brought to light the need for uniform screening standards. In 1948, the Illinois Statewide Joint Professional Committee on Children's Vision was formed through action of the Illinois Society for the Prevention of Blindness. This committee, representing both ophthalmology and optometry, provided a major impetus in the establishment and maintenance of the present vision screening program.

In the early 1960s, the society collaborated with two state agencies, the Illinois Office of Education (then Office of the Superintendent of Public Instruction) and the Illinois Department of Public Health, to establish an administrative structure for the vision screening program. Since the screenings would be done in the schools, the Illinois Office of Education was selected as the administrative agency. Miss Caroline Austin was employed as vision coordinator, and a formal

training program for nurses and technicians was begun through her efforts. Two years later, in 1964, the administrative structure of the program was shifted to the Illinois Department of Public Health, where it has remained. That same year, the heads of the three involved agencies signed a tripartite agreement, outlining the lines of responsibility of each agency, and pledging to cooperate and maintain the vision screening program. Representatives of the three agencies formed the Interagency Committee on School Vision Screening and assumed responsibility for coordination of the program. The Illinois Statewide Joint Professional Committee began meeting at least yearly with the interagency committee, evolving into an advisory committee that recommends appropriate methods and procedures for screening.

In August of 1971, a legal mandate for the program was achieved when Governor Ogilvie signed House Bill 2113 into law. This amendment to the School Code of Illinois (Sec. 27–8) provided for mandatory vision screening tests at first entry into school and at fifth and ninth grades.

The hearing portion of the Illinois Department of Public Health Vision and Hearing Program also began outside of the department. A 1947 demonstration project in Will County, conducted by the county health department, is considered to be the seed from which the current program has grown. Other county health departments adopted the Will County project as a model, and hearing screening began to spread throughout the state. A major problem encountered in these early programs was the lack of trained personnel. Audiometry was still in its infancy and few training centers had been established. The Illinois Department of Public Health, in 1949, assumed the responsibility for training audiometrists. Training institutes were begun at the Illinois School for the Deaf in Jacksonville under the joint sponsorship of the Department of Public Health, the Department of Public Welfare, and the Division of Services for Crippled Children. In 1962, the Committee on Hearing Conservation and Rehabilitation of the Illinois Commission for Handicapped Children studied the status of hearing conservation in the state's public and parochial schools. The study revealed many program problems and resulted in a recommendation for the employment of a coordinator of hearing conservation. The Illinois Department of Public Health established the position in 1963 and employed Mr. Raymond Bernero in 1964. Mr. Bernero developed a health services project application that was submitted to the U.S. Department of Health, Education, and Welfare in December of 1966. The primary objective of the application was to

secure funds for the establishment of a training program of short-term courses for audiometric technicians. Some seven months later (July, 1967), the Department of Health, Education, and Welfare approved and funded the application. This action resulted in the establishment of an annual training program.

In the spring of 1965, the Illinois Commission on Children accepted the responsibility of developing a statewide master plan for comprehensive services for hearing-impaired children in Illinois. The plan reports findings of the commission and lists recommendations for the development of coordinated programs beginning with hearing screening (identification audiometry) and following through with a hearing-impaired child to the point of preparing him for adult employment status.

One recommendation in the plan contributed considerably to the growth of the hearing program within the department. The recommendation called for the enactment of legislation authorizing the department's director to establish and administer a program of hearing screening services for all Illinois children. This resulted in "The Child Hearing Test Act," which was signed by Governor Ogilvie on September 25, 1969, and for which $75,000 was appropriated.

Early activities of both the vision and hearing programs and their staffs were concentrated on the development of program standards, techniques and criteria. The training of local personnel for the purpose of delivering valid and reliable screening tests, the development of effective and efficient programs, and enhancement of program evaluation skills also received early program emphasis. Although program standards, techniques, and criteria were developed early, they have been subjected to many critical reviews, modifications, and additions during the development of both programs.

A review of program activities, including the number of technicians trained, staff additions made, penetration levels screened, grants given to local agencies and program budgets, provides the best means of documenting growth and development. Data will be presented in this section for the purpose of demonstrating growth and development of the vision and hearing programs.

Both the vision and hearing programs have experienced the employment of professionals who are dedicated to their tasks and, as a result, have continued their employment for long periods of time. The vision program has had but three statewide coordinators from 1964 to 1977. These three persons, along with the other members of the vision staff listed below, have contributed substantially to the vision program throughout the years.

Coordinators
Caroline Austin—1964–1971
Henry Meyer—1971–1974
George Kording—1974–present

Supervisors of Vision Training
Harry Bostick—1968–1970
Rosemary Lemanski—1970–present

Regional Vision Consultants
Henry Meyer—1967–1971
Rosemary Lemanski—1966–1970
George Kording—1971–1974
Catharine Higgins—1966–present
Richard Webster—1971–1972
Corinne Cloppas—1973–present
Gladys Niggli—1974–present
Ronald W. Bennehoff—1975–present

Many of the persons currently employed within the hearing program have also been involved in it for several years:

Coordinators
Raymond Bernero—1964–1968
Phil B. Shattuck—1968–1973
James R. Nelson—1973–present

Supervisor of Hearing Training
James R. Nelson—1970–1973
Michael R. Larson—1975–present

Regional Hearing Consultants
Phil B. Shattuck—1967–1968
Mary Borton—1970–1973
Mary Ruth Whitman—1971–present
Michael R. Larson—1972–1975
Donald E. Geyer—1972–1975
George Stevens—1973–present
Keith Rowley—1973–present
John Pitzer—1975–present
Clarence Holloway—1975–present

In 1970, the position of chief of the Vision and Hearing Section was created. The following have served in that capacity:

Chief, Vision and Hearing Section
Caroline Austin—1970–1971
Phil B. Shattuck—1971–1977

Unfortunately, a fire in December, 1973, destroyed the majority of data gathered from the early years of the programs. It was thus necessary to estimate some of the following data.

VISION AND HEARING GRANTS TO LOCAL AGENCIES

Fiscal Year	*Amount*
1972	$120,000
1973	316,000
1974	389,000
1975	409,000
1976	601,000
1977	659,000
1978	659,000

NUMBER OF CHILDREN SERVED IN OTOLOGIC/AUDIOLOGIC CLINICS

Fiscal Year	*Number*
1966	200
1967	Unknown
1968	215
1969	183
1970	Unknown
1971	470*
1972	500*
1973	1,043
1974	1,348
1975	1,318
1976	1,091
1977	1,300

* Estimated

CHILDREN SCREENED

Fiscal Year	*Vision*	*Hearing*
1963	136,000	Unknown
1964	383,000	Unknown
1965	400,000*	Unknown
1966	420,000*	Unknown
1967	440,000*	200,000
1968	453,000	275,000
1969	548,000	450,000
1970	750,000	550,000
1971	1,000,000	725,000
1972	1,200,000	850,000
1973	1,270,000	1,000,000
1974	1,463,000	1,250,000
1975	1,539,000	1,325,000
1976	1,594,000	1,400,000
1977	1,585,000	

* Estimated

TRAINING COURSES

Fiscal Year	*Number Trained*	
	Vision	Hearing
1963	Unknown	Unknown
1964	Unknown	Unknown
1965	Unknown	Unknown
1966	80*	17*
1967	120*	26
1968	160*	180
1969	200*	100
1970	200*	250
1971	200	210
1972	250	215
1973	270	260
1974	280	230
1975	220	240
1976	220	240
1977	170	190
	Current Trained Active	
	1,875	1,850

* Estimated

The department's Vision and Hearing Program has evolved from being primarily concerned with the identification of high-risk school-age children to being concerned with the vision and hearing of individuals of all ages. While preschool and school-aged children receive the major emphasis of the program, more and more programmatic activities are being devoted to infants and adults. The program has expanded its activities beyond the narrow scope of identification. Each year the staff devotes more and more time to health education and diagnostic, follow-up coordination, and integration activities.

The Vision and Hearing Program was recognized as one of the more comprehensive and well-developed programs in the nation. The National Society for the Prevention of Blindness, the American Speech and Hearing Association, and the United States Department of Health, Education and Welfare, consulted with program personnel and utilized guidelines, training manuals, and other documents developed in Illinois as models for similar efforts in other states.

Medichek Program—Funds from federal and state sources have been made available to the Illinois Department of Public Aid for providing medical assistance to eligible residents of Illinois. Eligibility, broadly, refers to public aid clients, and the funds involved are referred to as "Medicaid" funds.

The 1967 amendments to Title XIX of the Social Security Act added a requirement to Medicaid directing attention to preventive health services and to early detection and treatment of diseases among children eligible for medical assistance. This extension of the Title XIX Medicaid Program into the field of preventive medicine is commonly called the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) amendment.

The involvement of preventive medicine brought the department into the picture. Recognizing that the preventive aspects for improving health (Early and Periodic Screening) is the domain of the Department of Public Health, the two agencies, Public Aid and Public Health, effected a contract wherein the Department of Public Health would be responsible for the medical screening portion of the program. This was called *Medichek.* Its purpose is to establish and mobilize methods of delivering continuous health care to children of parents on public aid.

All children from birth through twenty years of age who were eligible for medical assistance under the Medicaid Program were eligible for Medichek.

By contractual arrangement (revised and updated in August,

1973) with the Department of Public Aid, the department became responsible for:

1. Developing a client entry subsystem outlining the steps by which public aid clients could enter the program.
2. Developing a services subsystem that would identify vendor agencies approved for screening programs and the documentation of the eligibility of vendor agencies to deliver Medichek services.
3. Developing a follow-up subsystem, itemizing objectives for follow-up and procedures for conducting a program of adequate follow-up measures.
4. Developing a records subsystem for maintaining control records.
5. Developing a reporting subsystem in order to provide sufficient information to meet federal reporting requirements and for making management decisions. Sufficient information was considered as that which includes operations, evaluations, accountability for budget expenditures, commodities, inventory control, and personnel.
6. Evaluation of the program through determination of effectiveness, efficiency, and adherence to federal guidelines.
7. Maintaining a computer system to record each patient's identification and health record, the name of each health provider serving each child patient, and all payments authorized and made for each such patient.
8. Preparing a cost analysis for justification of all personnel, equipment, and commodity expenditures charged to the Medichek program.
9. Preparing and distributing to provider agencies all information for their proper participation in the program.

These were the major responsibilities the department undertook and effected over a number of years of preparation and organization—the entire operation being financed by the Department of Public Aid.

As a result, Medichek eligible patients taking advantage of this program have been provided with the following health services:

1. Periodic health appraisals obtained by a history and physical assessment with particular emphasis on growth and development.

2. A comprehensive immunization program and updating of previous immunizations. Immunizations provided have been for poliomyelitis, diphtheria, pertussis, tetanus, measles, rubella, and mumps.
3. Periodic screening, including tests for urine sugar; protein, hemoglobin, or hematocrit determinations; and tuberculin testing.
4. Screening when indicated to detect specific conditions, including lead poisoning, sickle cell abnormality, and venereal disease.
5. Vision and hearing screening at intervals from age three and above.
6. Dental assessment at age three and above.

Payment for further diagnosis and for conditions found through Medichek is provided through the Medicaid program of the Department of Public Aid.

The program reaches more patients each year. The parents of eligible patients are contacted by outreach workers or case workers to acquaint them with the program and to encourage their participation.

Chapter 6

INSTITUTIONAL PROGRAMS

This chapter deals with the programs related to those major facilities that provide health care services. Of the programs to be discussed here, three involve licensure. The department has always resisted, as best it could, the assumption of programs requiring licensure. It was felt that licensure bordered upon police action and that public health action should be related primarily to education. Despite the licensure authorities vested in the department, it has pursued every educational and voluntary cooperative channel available before invoking its mandatory authority. The department has long recognized the principle of self-regulation and the inherent desire of most individuals and facilities to conform to acceptable practices and to meet standards. There have been instances, of course, where this attitude does not prevail. Most of the statutes involved, however, contain sufficient democratic safeguards to preclude arbitrary or precipitous action by the department. These are, at times, frustrating and cause many days and dollars to be expended. Too frequently, it gives an impression of departmental indecisiveness.

Nursing Homes (Long-Term Care Facilities)

The "Nursing Home Act" was approved on July 17, 1945, and designated the administration thereof to the Department of Public Health. The department neither sponsored nor supported the legislation.

The act, as passed, exempted county-operated homes; "rest" homes, licensed or approved by the Department of Mental Health; facilities licensed by the Department of Children and Family Services; state– and federally-owned facilities; and homes licensed under local ordinances that were equivalent to state standards. The cities

of Chicago, Evanston, Joliet, Oak Park, and East Saint Louis enacted such ordinances.

A nursing home was defined as any facility, whether operated for profit or not, that housed three or more persons needing nursing care because of physical infirmity.

Within the department, responsibility for administering the act was assigned to the environmental unit then known as the Division of Sanitary Engineering. A sanitary enginner, Robert R. Cunningham, was selected to head up the program. It soon became apparent that nursing expertise also was necessary. A public health nurse, Margaret Ranck, R.N., was also assigned to the program by the Division of Nursing. Within two years, standards and regulations had been established and approximately 200 homes licensed. Operated as a centralized program, inspections were made by the field staff of the department or by local health department staffs. The state fire marshal's office conducted fire safety surveys for the department.

The program and staff were transferred to the Division of Hospitals in 1949, and a nursing home section was established.

In 1951, the Nursing Home Act was amended to include county-operated nursing homes, and established nonprofit homes for the aged as a category separate from nursing homes. A "home for the aged" was defined as any facility, operated not-for-profit that provided maintenance and care to three or more persons in need of care because of illness or physical infirmity.

Also in 1951, the Illinois Nursing Home Association and the Illinois Association of Homes for the Aged were organized. The Metropolitan Chicago Nursing Home Association was formed at about the same time.

In the latter part of the 1950s, Federal Housing Administration (FHA) mortgage insurance was made available for construction of nursing homes. This started a boom in the building of new structures specifically for nursing home services.

In 1957 the Advisory Council on Nursing Homes was created.

In 1960, the nursing home standards were revised to require that any newly opened or constructed nursing homes must meet FHA basic standards and Hill-Burton physical plant standards. (The Hill-Burton program will be discussed later in this chapter.) This revision was adopted to stop the conversion of unsafe and unsuitable buildings to nursing homes. Also, it was felt that there were enough nursing home beds available to negate the need to convert old buildings. No one not involved could appreciate the fact that the department had been on the horns of a dilemma. To enforce desirable conditions stringently and precipitously would have closed

so many nursing homes that available facilities would have been quite inadequate to accommodate those in need of such care. So, dependence was placed upon, and effort directed toward, the upgrading of facilities as soon as practicable and feasible. Flagrant violations, of course, resulted in action for closure.

Also in 1960, Hill-Burton grants-in-aid, heretofore limited to hospital construction, were made available for the construction of nursing homes by not-for-profit and for tax supported agencies.

The standards, as revised, were declared illegal by the attorney general, contending that the same standards must be applied to all nursing homes without singling out newly opened or constructed homes.

By 1961, the Nursing Home Act had been further amended to include "sheltered care homes," defining such facilities as a home with three or more persons requiring personal care because of age or infirmity but not nursing care. Soon thereafter the Illinois Sheltered Care Home Association and the Chicago Residential Care Association were formed. Also, factions within the Illinois Nursing Home Association came to a parting of the ways, resulting in the formation of yet another organization—the Illinois Nursing Home League.

In order to overcome the objections of the attorney general as noted above, the department again revised its licensing standards in 1961. Essentially the same standards were retained for newly opened or constructed nursing homes, but there was added the provision that by January 1, 1970, all nursing homes would have to meet the "newly constructed" standards or convert to a sheltered care home. These revised standards were reviewed and approved by the Nursing Home Advisory Council, which had been created in 1957 by amendment to the Nursing Home Act. The director approved and set February 1, 1962, as the effective date for the implementation of the revised standards.

The act was again amended on August 8, 1961, broadening the defintion of a sheltered care home, clarifying what constitutes "personal care," and requiring homes already licensed under local ordinance to also be licensed by the department. The state license was issued if the local standards were no less stringent than the state's.

Up to this time, the nursing home section was responsible for coordinating the program and for issuing licenses. The regional offices and local health departments made the inspections, interpreted conditions and advised the section concerning the issuance of a license. The Division of Sanitary Engineering objected strenu-

ously to the use of its engineers in this program, contending that the time consumed was adversely affecting its mandated programs. As a consequence, the title of geriatric home advisor was established and two persons in this classification were employed for each region. They were given training in the physical plant and sanitation of nursing homes.

This decentralized system resulted frequently in disparate interpretations of the standards—a situation the nursing home section tried valiantly to correct through numerous staff conferences with the personnel making surveys.

Early in 1964, the Departments of Public Health and Mental Health agreed that the licensing of private mental health facilities and institutions should be a function of the Department of Public Health. The staff of the nursing home section of the Bureau of Geriatrics participated in developing the legislation necessary to effect the transfer. The 74th General Assembly in its 1965 session enacted, and Governor Kerner approved, the legislation (H.B.1873 to 1876, inclusive). The types of institutions that thus became the department's responsibility for licensure were mental rest homes and residential schools for the mentally retarded, not under the Department of Children and Family Services. This activity was assigned to the nursing home section.

A committee representing the Departments of Public Health, Mental Health, and Children and Family Services was established to coordinate the transfer. The latter two departments agreed to act as consultants in matters relating to their areas of expertise.

With the passage of Public Law 89–97, better known as "Medicare," Governor Kerner designated the department as the official state agency to implement the provisions of Section 1864, Title XVIII, of the Social Security Act. This law affected hospital facilities, home health agencies, and long-term care facilities. The initial task involved the identification of all providers of care with potential for participation in Medicare. This was followed by distributing to each potential provider an application kit containing the federal guidelines, requirements, and forms to be completed in order to establish eligibility for participating in Medicare benefits. The nursing home section was responsible for certifying the eligibility of long-term care facilities to the U.S. Department of Health, Education, and Welfare.

On July 31, 1967, the governor approved Senate Bill 1608. This was another amending of the Nursing Homes, Sheltered Care Homes, and Homes for the Aged Act. The amendment permitted the licensing of sheltered care homes as part of a county nursing home

or a home for the aged. It also allowed the department to adopt classifications of the license of homes to the levels of service; and, if classification was so adopted, the applicable minimum standards were to define classification. In accordance therewith, licensing standards were revised to license by levels of service and distinct parts of one facility. The revision also incorporated most of the Department of Health, Education, and Welfare standards for certification.

In the early part of fiscal year 1968, the Division of Hospitals and Chronic Illness, under Roger F. Sondag, M.D., M.P.H., was renamed the Division of Health Care Facilities and Chronic Illness. Under it, the new Bureau of Health Care Facilities absorbed the hospital licensing program, the hospital and medical facilities survey and construction program, the hospital reimbursable cost program, the hospital maternity service study program, the newly established rehabilitation program, and the long-term care program. George Lindsley, M.P.H., resigned and was replaced by Harold E. Josehart, M.S.H.A., as chief of the Bureau of Health Facilities. The other bureau, Chronic Illness, was headed by William J. Cassel, M.D., M.P.H.

Along with these changes, the long-term-care program was placed in the Licensure and Certification Section. An administrative position, Medicare-licensing program representative, was established in each of the regional offices to supervise the nurses and geriatric home inspectors assigned to licensing and certification surveys. Local health departments were practically stripped of participation in the program. The central office staff in Springfield was enlarged.

Within the office of the chief of the Division of Health Care Facilities, there was established a federal program section to coordinate the certification process with quality control added to its responsibilities somewhat later.

On September 22, 1969, the governor approved Senate Bill 1040, "An Act to License and Regulate Nursing Home Administrators." Responsibility for administration was placed in the Department of Registration and Education. The law empowered that department to suspend, revoke, or refuse to renew certificates of registration upon specified grounds; to impose penalties; to establish qualification standards; and to conduct qualifying examinations. Its purpose, of course, was to upgrade nursing home operations and care.

By June 30, 1969, the following facilities had been licensed: 604 nursing homes having 37,095 beds; 305 sheltered care homes having 8,032 beds; and 130 homes for the aged with 13,442 beds.

Of these, 174 facilities had, in total or distinct part, been certified as extended care facilities under the Medicare program and represented 11,013 Medicare beds.

When the reorganization of the department became effective in 1970, what had been the Bureau of Health Facilities within the Division of Health Care Facilities and Chronic Illness, became the Division of Health Facilities within the Bureau of Personal and Community Health. The licensure and certification section was discontinued with its licensing and Medicaid certification responsibilities for long-term-care facilities assigned to the long-term-care section.

In the 1971 fiscal year, the initial development began of an automated system for the regulation and medical review of long-term-care facilities and patients, including the issuance of licenses to facilities by levels of service (skilled nursing, intermediate care, and sheltered care). The revision of standards, initiated earlier, was completed in June, 1970, and standards were so reorganized as to make them compatible with the computer operation. With this accomplished, licensing and certification information was fed into the computer, and computer-produced licenses were issued thereafter.

Harold Josehart resigned his position during the year and was replaced as chief of the Division of Health Facilities by Paul X. Elbow, M.S.H.A.

Approved on September 10, 1971, was House Bill 854, which created "the Health Care Licensure Commission to study the status and problems of licensure and regulation as it affects health care delivery in Illinois, and recommend solutions to the general assembly by March 1, 1973." Membership consisted of six members of the senate, six members of the house of representatives, and eight members appointed by the governor. The commission made abundant use of department expertise and proposed a number of solutions that were later adopted administratively or by statute.

Fiscal year 1972 recorded some significant advances in the long-term-care-facilities program. The United States Department of Health, Education, and Welfare granted funds to the department to evaluate its automated licensing and certification system for long-term-care facilities and to conceptualize a comprehensive system that might be utilized by other states. This grant of $279,760 came as the result of the department having developed the first totally computerized system for licensure and certification of long-term-care facilities in the United States.

The tragic fire that destroyed the Carver Convalescent Home in

Springfield prompted a review of fire-safety requirements. As a result, minimum standards for nursing homes were revised to emphasize the pertinent requirements of the Life Safety Code of the National Fire Protection Association, and an accelerated effort was made to bring about the installation of sprinkler systems in those facilities required to have them under the Life Safety Code.

In the spring of 1973, Michael Werckle, M.D., was appointed as chief of the Bureau of Personal and Community Health.

Beginning in August, 1973, three goals to improve the long-term-care licensure program were implemented.

The first was an involved, systematic examination of the extent to which existing legislation allowed optimum fulfillment of responsibilities for insuring quality health care. After having completed this analysis, legislation was sought and obtained providing for—

- a consumer dominated Long-Term-Care Advisory Board
- disclosure of all shareholders with a greater than 10 percent interest in a facility
- unannounced survey visits
- establishment of a rate review commission
- authority to withhold specific (categorical) funds from facilities until identified deficiencies were repaired or eliminated.

The second involved examination of Illinois standards to determine compliance with federal standards. In order to achieve compliance with the federal standards of January, 1974, the Department of Public Health completely rewrote the state standards, not only to comply with those required federally, but to supplement them where needed to assure quality of care. New regulations consonant with enforcement of the revised standards were promulgated.

The third emphasized comprehensive training for the licensure and certification of survey staff. These surveyors were required to be professionals in their chosen fields and be thoroughly familiar with federal standards, Illinois standards, and the system within which and under which they must function.

Three weeks of formal training was provided to every newly employed survey staff member, supplemented by two weeks of continuing education for each surveyor. All Illinois surveyors must be proficiency tested in order to make sure of their knowledge and capability in surveys.

The automated survey process evaluates a facility's potential for providing care and services. The emphasis is upon the facility rather than the resident. Licensure must also include the actual deliverance of quality care to those persons who live in long-term-care facilities.

The department has piloted a new method to evaluate quality of care and the extent to which needs for care are fulfilled by the long-term-care facility. The Quality Evaluation System, referred to as QES, was designed to measure the delivery of care to residents. The Quality Evaluation System is sophisticated and computerized. The survey instruments are different from the present licensure survey forms and the surveyors view the long-term care facility in a different way. For example, if a resident needs the services of a dentist, the important factor is the identification of the need for dental care and service to those people who have the need.

The Quality Evaluation System does not do away with licensure rules and standards. Standards for long-term-care facilities are necessary for many obvious reasons. The purpose of the Quality Evaluation System is simple, i.e. to determine if quality care is being delivered and if services are being provided to meet needs.

In 1975, Doctor Werckle reorganized the Office of Health Facilities and Quality of Care. Thus there came into being the Divisions of Geriatric and Long-Term-Care Programs; Hospital, Laboratories and Acute Care; Development and Construction; Planning and Conformance; and Ambulatory Care Review. Also a separate section, Curriculum Development, was established.

Shortly thereafter, on December 1, 1975, Paul X. Elbow resigned. William Irvine, M.B.A., became chief of the Division of Geriatric and Long-Term-Care Programs; Michael Grobsmith, chief of the Division of Hospitals, Laboratories and Acute-Care Facilities; Aden Clump, M.A., chief of the Division of Development and Construction; George Lindsley, M.P.H., chief of the Division of Planning and Conformance; and Mary Beck, M.P.H., chief of the Division of Ambulatory Care Review.

On February 28, 1977, Doctor Michael Werckle resigned and was replaced as associate director of Health Facilities and Quality Care by Patricia A. Nolan, M.D.

During the Lashof administration, two important legislative acts were proposed and passed. A consumer dominated Long-Term-Care Advisory Board was created, and applicants for licenses to operate nursing homes were required to reveal the identity of all shareholders. By opening long-term-care services to public scrutiny, the system can presumably be made accountable to consumers.

In the spring of 1976, there were 971 long-term-care facilities licensed by the department, of which 21 percent were providing more than one level of care. These 971 facilities had a total of 96,630 beds.

A program is planned to train at least one person from every long-

term-care facility in the state. That person will then be responsible for teaching patient care to nurse aides, who are usually responsible for the bedside care of the patient.

The history of the regulation and improvement of long-term care in Illinois is a chronicle of an uphill and determined effort by dedicated, and often maligned, individuals to obtain quality care for those in need. Hemmed in by limitations beyond their control, these good people in the government service have fought valiantly for adequate authority, for sufficient funds and personnel, for public understanding and support, and for cooperative effort to bring their objectives to fruition. Criticism and investigations have been endured and even welcomed in the hope that they might help. Currently there is little evidence that nursing-home care is a priority public issue, yet those involved continue to work for better days ahead.

Rehabilitation

This program is presented at this point because it relates closely with long-term care.

On April 1, 1967, a rehabilitation section was established in the Bureau of Geriatrics in the Division of Hospitals and Chronic Illness. This came about largely because of the transfer of the so-called Approval Program from the Department of Public Aid to the Department of Public Health. This program was for health-related facilities that were maintaining rehabilitation nursing programs and/or rehabilitation activity programs of some sort and wished to have them approved. Thus, the department became the approval agency responsible for the evaluation of a facility's rehabilitation effort.

A second program of the rehabilitation section was an educational one designed to train nursing home personnel in the development of rehabilitation nursing and activities. This rehabilitation education service was made available upon request to licensed nursing homes and to those homes for the aged that were licensed to provide nursing care.

The ultimate objective of a restorative rehabilitation program is to assist the residents of the facility in becoming as physically, mentally, and socially self-sufficient as possible and includes learning or relearning those skills necessary to participate in competitive life and for eventually living in a less structured environment. In order to qualify for additional payment from the Illinois Department of Public Aid or the Department of Mental Health for a restorative program, a facility must meet all the licensing requirements of the Illinois De-

partment of Public Health, be currently licensed and maintain specific program standards.

When the Division of Hospitals and Chronic Illness became the Division of Health Care Facilities and Chronic Illness in November, 1967, the Bureau of Geriatrics, including the rehabilitation program, was integrated into the Bureau of Health Facilities.

In June of 1968, a psychiatrist and a consultant in speech pathology were employed. Even with added staff, the requests for rehabilitation services accelerated beyond the section's ability to keep up with the demand. During fiscal year 1968, the Rehabilitation Evaluation Committee completed 120 evaluation visits—78 to nursing homes and homes for the aged and 42 to sheltered-care homes.

In 1970, the rehabilitation education program was changed in an effort to reach the ever-increasing number of facilities requesting assistance. A five-day workshop was held for a group of twenty facilities with one- or two-day follow-up visits made to each of the facilities represented at the workshop. Thus twenty facilities were given service in approximately the same time as six or eight would have taken.

In order to effect a new social rehabilitation program, the rehabilitation section began to make plans, developing criteria and standards for the new incentive program. The social rehabilitation program was implemented on July 1, 1972. Responses by long-term-care facilities to the new effort were eager and numerous. This program, along with the educational service and the evaluation service, continued to expand and to bring about successful restorative programs for patients in need.

Activity and recreation program content is initially evaluated by the rehabilitation and education section and then periodically resurveyed for compliance. A specific, planned program of group and individual activities is geared to the resident's individual needs, as reflected in the individual care plan and embracing at least a reasonable number of hours on a daily basis. Residents are encouraged and given the opportunity, with realistic choices and options, to be involved in all aspects of programming, including planning and critique, with allowance being made for individuals to develop their own activities. A planned volunteer and/or auxiliary effort that assists with the program and is under the direction of someone in a supervisory capacity is also a part of the activity program.

Rehabilitation nursing aspects must have the prerequisite of an approved or approvable activity program. Rehabilitation nursing programs require a full-time registered nurse, who is trained in rehabilitation nursing, to supervise nursing service in a nursing care

facility. There must also be a sufficient number of trained staff to provide an identifiable restorative nursing program in connection with resident care on a twenty-four-hour, seven-days a week basis in a nursing care facility, or a sufficient number of personal care staff to provide care on a twenty-four-hour, seven-days a week basis in a sheltered care facility.

Criteria for the Social Rehabilitation Supplemental Program include the prerequisite of an approved or approvable activity and rehabilitation nursing program in a nursing care facility, or an approved or approvable activity program in a sheltered care facility.

In facilities with 100 or more beds, a full-time, professionally qualified person is required to be the social rehabilitation director. In facilities under 100 beds, the social rehabilitation director must be a high-school graduate or equivalent, and be in this position full time. If the facility does not employ a professionally qualified person, it must utilize the services of a professionally qualified consultant to the program. Additional personnel are provided as necessary to meet the needs of residents and the program, and the entire process is continually re-evaluated.

Hospital Licensure

The department's first major program involving hospitals began in 1939 when the law was amended transferring the maternity hospital licensing program from the Department of Public Welfare to the Department of Public Health. In 1949, the standards for maternity and newborn hospital licensure were revised and updated, with increasing attention directed at standards of patient care. From 1949 to 1953, a number of significant changes in hospital maternity–newborn services were brought about—among them physically separate obstetrics departments, separate staffing of obstetrical departments, stricter controls for the prevention of infections, special facilities for premature infants, formula preparation, and others.

Another major step was taken to broaden the department's health facility licensing authority as a result of federal Public Law 725, the Hospital Survey and Construction Act, enacted by the 79th Congress in 1946. This was commonly known as the Hill-Burton Act. The act contained a provision that any hospital receiving federal funds under the act should comply with such minimum standards of maintenance and operation "as might be fixed in the discretion of the state." On July 1, 1950, the department promulgated its "Minimum Standards of Maintenance and Operation Required of Hospitals Constructed Under Public Law 725 and the Illinois Hospital Construction Act."

Authority to do so was contained in the limited Hospital Licensing Law enacted in 1949 by the 65th General Assembly. Primarily responsible for preparing these early standards were George K. Hendrix, B.S., chief of the Division of Hospital Construction and Services, and George A. Lindsley, M.P.H., a hospital consultant.

This was the department's first venture in establishing licensing standards applicable to an entire general hospital. Most states, including Illinois, had no general hospital licensing laws up to that time. It is, therefore, significant to note that these first "Minimum Standards" contained standards relating to hospital administration, governing board, and medical staff. It should be noted that this was done in Illinois when many general hospitals were not accredited by the American College of Surgeons or its successor, the Joint Commission on Accreditation of Hospitals.

Bills to enact a comprehensive hospital licensing act were first drafted in the Division of Hospital Construction and Services. Efforts to enact the law in the 66th General Assembly (1949) failed. Few states had such laws at that time.

On August 28, 1950, the 81st Congress enacted the "Social Security Act Amendments of 1950." It included a provision affecting the approval of a state's public assistance plan: such a plan, "must, effective July 1, 1953, provide, if the plan includes payments to individuals in private or public institutions, for the establishment or designation of a state authority or authorities which shall be responsible for establishing and maintaining standards for such institutions." The standards were to pertain to the health, welfare, and safety of such individuals in such institutions. This federal action provided further impetus to enactment of a hospital licensing law in Illinois. However, the effort in the 67th General Assembly in 1951 was again unsuccessful, probably because the federal deadline was not until July 1, 1953.

In May, 1953, the bill was again introduced and strongly supported by the Illinois Hospital Association. It was passed on July 1, 1953. The federal deadline had been met.

The law required all hospitals, except those operated or licensed otherwise by the state and federal governments, to obtain annually renewable licenses from the department. It likewise required any person or agency proposing the construction of a hospital, or additions to or alterations of existing hospitals, to obtain approval of plans from the department before proceeding. The law also created a hospital licensing board of seven members, appointed by the governor. The Board's approval is necessary before any rule prepared by the department becomes valid.

The Program—In 1961, when Doctor Yoder became the director of Public Health, the hospital licensing program was in the Bureau of Hospitals, one of three bureaus in the Division of Hospitals and Chronic Illness. George A. Lindsley, M.P.H., was chief of the bureau. By that time some 300 hospitals in Illinois had been licensed.

Each hospital that provided maternity and newborn care was making a monthly report of its obstetric activities. This was done voluntarily and included some 220 hospitals. These statistics provided an understanding of conditions, trends, and results in hospital and medical care of mothers and infants, with unusual occurrences, deaths, or infections referred to public health physicians for follow-up.

These statistics, gathered since 1943, were compiled and analyzed, and a summary, *Services for Mothers and Infants in Illinois Hospitals—A Twenty Year Summary*, was published by the department in 1964. Doctor John H. Rendok, consultant in maternity, and Alice S. Flesch, R.N., were the authors. The study showed maternal mortality in Illinois to be 21.36 maternal deaths per 10,000 live births in 1943, compared with only 2.73 in 1962. The department's programs of licensure and maternal and child health must be credited with contributing substantially to this favorable result.

The Hospital Licensing Act, despite the fact that it contained no direct authority to regulate the establishment of hospitals, was used during the early 1960s to deter the establishment of many additional hospitals, particularly in the suburban Chicago area. Many of the large urban areas of the nation had experienced a sudden proliferation of general hospitals in suburban areas, often of proprietary nature and often sponsored by developers and a variety of "fast-buck" artists. The department, with the support of the governor and the attorney general, determined to stop this development in Illinois. This was undertaken as an administrative procedure of the Bureau of Hospitals in the Division of Hospitals and Chronic Illness. Each of these proposals was thoroughly investigated and analyzed, and the sponsors were informed that the findings would be made public. Some seventeen new hospitals proposals were so investigated; only one (the first one, already completed) was ever established.

This experience provided the impetus for the enactment of Senate Bill 397 (the Gottschalk amendment), approved August 2, 1965. This amended the Hospital Licensing Act and required that a permit be issued from the department to construct a new hospital. The amendment also increased the Hospital Licensing Board from seven to nine members, and gave the department the responsibility for licensing psychiatric hospitals and psychiatric sections of general

hospitals. The bill, as introduced, contained a significant provision, stating that, in order to obtain a permit, "there be a demonstrated need for the hospital in the community to be served." There was, however, strong opposition to this provision from certain professional and institutional provider groups. The "need" clause was struck out. However, the Gottschalk amendment must be considered the forerunner of what came to be "certificate of need" legislation (see chapter on "Comprehensive Health Planning").

By the end of fiscal year 1966, 330 hospitals had been licensed; and, by June 30, 1967, 290 hospitals had been certified for Medicare.

During fiscal year 1968, the decline in the birth rate resulted in the lack of occupancy of many maternity beds, especially in the larger hospitals. A program was instituted, therefore, to aid hospitals with over 400 deliveries a year by allowing the use of unoccupied maternity beds for "clean" gynecologic patients. A total of eighty-six hospitals took advantage of this. The program helped to alleviate an acute bed shortage in medical and surgical departments of these eighty-six hospitals by 11 percent. The next year the number of hospitals participating rose to ninety-two.

In the spring of 1969, another legislative effort was made to extend the department's permit authority to cover existing as well as new hospitals so as to apply to construction of new buildings or additions or major alterations to existing hospitals and to the establishment of a new service. This bill, Senate Bill 1145, was defeated.

This was followed by the introduction of House Bill 2653 on April 30, 1971, entitled the "Illinois Health Facilities and Service Planning Act." After numerous amendments in both the house and senate, it, too, was defeated.

During fiscal year 1972, revisions to the licensing requirements provided, among other changes, that no hospital building or any part thereof out of compliance with certain building and safety codes could be used as a patient care area after December 31, 1976.

On October 14, 1969, the governor approved Senate Bill 568, which amended the Emergency Medical Treatment Act. This amendment made it mandatory for hospitals licensed by the department to provide emergency medical services "to any applicant who needs such emergency services." This legislation resulted largely from an episode in Chicago wherein a patient was shunted from hospital to hospital for emergency attention and expired in the process. In 1971, the Hospital Licensing Board recommended, and the director ap-

proved, that it be mandatory for hospitals to participate in an areawide plan for emergency services. This requirement has proved most effective in improving the availability and quality of emergency services.

On August 18, 1972, the governor approved House Bill 493, the Illinois Health Facilities Authority Act. This legislation provided for an authority of seven members, appointed by the governor, and the coordinator of health services. The powers and duties of the authority were designed to make municipal bond capital financing monies available for loans to not-for-profit health-care facilities. Illinois hospitals were enabled to borrow monies for longer periods of time and at lower interest rates through the authority. Existing debt could also be refinanced. Substantial savings and reductions in health-care costs were made by utilization of this method of borrowing money for constructing and equipping health-care facilities.

A major step forward in advancing health care was taken when Senate Bill 1609, known as the Illinois Health Facilities Planning Act, was introduced into the general assembly on May 28, 1974. This bill was supported (and subsequently approved) by the governor, the department, the Comprehensive State Health Planning Advisory Council, the Comprehensive State Health Planning Agency and the local and regional comprehensive health planning organizations. This legislation (PA 78–1156) is mentioned at this point because of its significant effect upon hospitals, as well as on other health-care facilities. It is described in some detail under "Comprehensive Health Planning."

During the law's first three years, the Illinois Health Facilities Planning Board was developed, and standards, criteria and plans were adopted for hospitals and long-term-care facilities. The board held forty-five meetings to review and approve or disapprove several hundred applications for construction or modification of health-care facilities.

The Ambulatory Surgical Treatment Center Licensing Program was established by Public Act 78–227 and revised on July 19, 1973, by Public Act 79–339. These statutes charge the department with the responsibility of assuring that all surgical procedures, including abortions, are performed under circumstances that insure maximum safety. This responsibility includes the development, establishment, and enforcement of standards for the care of individuals in ambulatory surgical treatment centers, and the construction, maintenance and operation of such centers.

Public Acts 78–759 and 79–654 provide for the development of

standards for facilities for the mentally ill and separate standards for facilities for the mentally retarded.

When the department was reorganized on January 1, 1974, the hospital licensing program was in the Division of Health Facilities, which in turn was under the Office of Health Facilities and Quality of Care. By February, 1977, this division had been divided into the Division of Geriatric and Long-Term-Care Programs and the Division of Hospital, Laboratories, and Acute Care. M. S. Grobsmith was made chief of the latter division.

Geriatric Transfer Program

In September, 1969, the Copeland legislation (House Bills 922 through 995E) was passed by the 76th General Assembly requiring that all patients in state mental institutions who have no acute mental illness, but whose mental condition is merely weakened or impaired by the aging process, be transferred to appropriate long-term-care facilities. It provided further that persons whose mental processes had been weakened by advancing years with no acute mental illness could not be admitted as patients to state mental institutions.

The department was made responsible for assisting in, and facilitating, the placement of eligible patients into appropriate long-term-care facilities. Implementation of this objective required the provision of information to placement committees concerning available beds based on a thorough knowledge of each patient's needs, and the services available in various facilities. The department was made responsible also for encouraging facilities with adequate services to participate in this program and to encourage facilities with minimal or substandard conditions to develop adequate services and programs.

By the end of fiscal year 1970, the department's geriatric transfer coordinators, in cooperation with the Departments of Public Aid and Mental Health, had transferred 425 geriatric patients from state mental hospitals to long-term-care facilities. Sufficient coordinators were employed by June 30, 1971, to cover all but three state mental hospitals; and, for every patient considered transferable by the screening committee, a suitable long-term-care facility was found.

An unusual development during fiscal year 1971 was the transfer of twelve geriatric patients from Menard State Prison. To accomplish this, the patients were discharged from the prison and visited periodically by a parole officer.

From the beginning of the program to June 30, 1972, more than

1,000 pateints had been transferred to licensed long-term-care facilities. Placements were also found for referrals from mental health zone centers and clinics.

Health Care Facilities Construction

On January 10, 1945, there was introduced into the U.S. Senate the "Hospital Survey and Construction Act," which came to be known, after its passage, as the Hill-Burton Act. The bill (U.S. Senate Bill 191), however, did not become law until the fall of 1946.

In the meantime, the department became aware of its contents and moved rapidly to get Illinois ready to participate. In response to a resolution by the Illinois Hospital Association on January 27, 1945, the department obtained gubernatorial authority to survey hospital facilities and hospital needs throughout the state. This was completed on July 22, 1947, and the survey report and need plan were approved by the surgeon general on August 8, 1947—some of the first of their kind in the nation.

Also on August 8, 1947, a parallel enactment, the Illinois Hospital Construction Act, was approved by Governor Green. The responsibility for the administration of this act was placed in the department; $80,000 appropriated for administration; $4,675,000 appropriated for state assistance in financing new hospital construction for the biennium; and a $5,533,047 federal grant received for the same purpose, through June 30, 1949.

An Advisory Hospital Council was appointed, and the Division of Hospital Construction and Service was created on September 5, 1947. The July 22, 1947, plan was used as a basis for drawing up a priority schedule for hospital construction throughout the state in order to distribute funds equitably. State and federal funds were limited to a maximum input of two-thirds of eligible project costs while the remaining one-third and all of the noneligible costs were required to be paid from local sources. Before the end of 1950, six of the first nine projects authorized were completed, open, and operating.

After 1951, no more state money was appropriated for hospital construction. The local projects were required to provide all necessary funds over and above the available federal money.

Grants from the federal government reached $6,696,734 for the year ending June 30, 1962, and rose to $7,035,732 for the year ending June 30, 1963.

Eligibility for federal aid initially applied to general hospitals, psychiatric units and hospitals, professional nurse training schools

and dormitories, public health centers, and public health laboratories. In 1954, the program was broadened to include nursing homes, rehabilitative centers, and diagnostic or treatment centers.

Hospital Construction Program

When Doctor Yoder came to the directorship, the Hospital Construction Program was administered by the Bureau of Hospitals, one of three bureaus in the Division of Hospitals and Chronic Illness.

During fiscal year 1962, five projects were approved, adding 486 beds to the state total. The following fiscal year, 1962–1963, six hospital projects were approved constituting a total of 814 beds.

The federal funds allocated to Illinois for the fiscal year 1964 amounted to almost eight million dollars. These funds were allocated to six general hospitals, five psychiatric units of general hospitals, one school of nursing, three skilled nursing homes, three diagnostic and treatment centers, three chronic disease units of general hospitals, and one rehabilitation center.

Almost eight million dollars of federal grants were allocated in fiscal year 1965, which, in turn, were given to approved projects for eight general hospitals, one psychiatric unit, one school of nursing, one public health center, two nursing homes, two chronic disease units, three diagnostic and treatment centers, and one rehabilitation center.

In fiscal year 1966, federal allocation of the so-called Hill-Burton funds rose to almost nine million dollars and was used to assist in financing 16 construction projects.

In fiscal year 1968, the Division of Hospitals and Chronic Illness was renamed the Division of Health Care Facilities, and the Bureau of Hospitals renamed the Bureau of Health Facilities. The construction program remained in the newly named bureau, which was now headed by Harold Josehart, M.S.H.A.

Public Law 88–164 made grant funds available to the Department of Mental Health for the construction of mental health centers and facilities for the mentally retarded. That department delegated the architectural evaluation and fiscal accountability aspects of the program to the planning and construction section of the Bureau of Health Facilities in 1968. Also delegated to the section were those provisions of Public Law 89–749 that required the State Comprehensive Health Planning Agency to assist each health-care facility in the state to develop a program for capital expenditures for necessary replacement, modernization, or expansion. At that time, the department was the state health planning agency with the planning

responsibilities vested in the Division of Health Planning and Resource Development.

Public Law 91–296, enacted in 1970, modified the Hill-Burton program to provide financial assistance for emergency health services and out-patient facilities, including neighborhood health centers, the latter replacing the old category of "diagnostic or treatment center." Also, funding assistance was expanded to include loans with interest subsidies, under the Hospital Construction Loan Program of the federal Department of Housing and Urban Development.

Throughout the life of the Hill-Burton program, there has been an annual revision and updating of the "Illinois State Survey and Plan for the Construction of Hospital and Medical Facilities." These are on file in the Illinois State Library and, for the interested reader, will provide details not feasible to include in a narrative of this length.

Federal grants reached a maximum of $9,701,331 in fiscal year 1969. Since that time, these funds have shown a substantial decrease with no funds appropriated in 1975 and since 1976. From time to time, high-level criticism has been given to the program, not because of its operation, but because it has been felt that the goal of sufficient hospital beds has been attained. Whatever merits this argument may have, it fails to recognize the continuing need for modernization and construction of health-care facilities other than hospitals.

On October 4, 1960, Aden Clump, M.A., came to the department. He has directly supervised the Hill-Burton program since 1967.

Fiscal year 1973 saw the start of a concentrated attempt by the executive branch of the federal government to withdraw all funding assistance under the Hill-Burton program. President Nixon issued an order impounding the funds. Several states sued the federal government and succeeded in getting the funds released. Next the 1974 appropriation was vetoed but overriden.

In December, 1974, the "National Health Planning and Resources Development Act of 1974" was passed. President Ford signed the bill January 4, 1975. The enactment signified the passing of emphasis on individual categorial planning and funding assistance. Basically the act combined Hill-Burton, regional medical programs, and comprehensive planning under two new titles (XV and XVI) in the Public Health Service Act. Although the new law did not delete Title VI under which Hill-Burton operated, Title XVI virtually covered the same thing; and congress, when discussing the proposal, kept referring to Title XVI as the Hill-Burton revisions. Title XVI provided for both grant and loan guarantee with interest subsidy assistance. The federal administration requested none in fiscal year 1975 and

very little in fiscal year 1976. Congress appropriated more, but implementing regulations were not developed. Therefore, the states as of 1977 have never received their allocation, so that projects could be assisted.

Fiscal year 1973 may have heralded the demise of grant assistance, but it did not signify the end of Illinois responsibilities or activities under Hill-Burton. As stated before, funding allocations were delayed for 1973 and 1974. It is anticipated that it will be 1986 before the last project is closed out. Even then, unless the laws are changed, the states, including Illinois, will be responsible for residual activities under the assurances given to the project applicants for at least twenty years, i.e., care below cost, change in ownership or project usage, and, in one instance, community service for an unknown period.

The following figures reflect the extent and accomplishments to date of the health-care facilities construction program by the department.

Analysis of Federal Funds Covering Project Allocations

A. Total Grant Funds	$154,688,874.64
I. Part C	
a. General and other hospitals	$ 87,156,192.56
b. Modernization	20,267,858.00
II. Part G—Medical Facilities	
a. Diagnostic and Treatment/ Outpatient	20,025,850.04
b. Rehabilitation Facilities	6,389,026.08
c. Long-Term Care	15,445,444.96
III. Accelerated Public Works	5,404,504.00
B. Total Loan Funds	$ 76,668,959.00

Recapitulation of Beds

General	18,324
Chronic	1,349
Mental	1,550
Nurses' Dormitory	128
Nurses' Training School	1,239
Tuberculosis	120
Long Term	4,103
Rehabilitation	736
Interm	38
Modernization	2,571
Public Health Center	—
Total	30,158

Recapitulation of Ownership Types

Nonprofit	241
County	21
District	21
City	16
State	6
Township	3
Public	2
Total	310

Number Reconciliation

Last number used	344
Plus Illinois 11b and 45b	2
Less projects cancelled	(36)
Total Projects	310

Clinical Laboratories and Blood Banks

The 73rd General Assembly enacted two significant laws relating to clinical laboratories and blood banks. Senate Bill 1103 required the registration of clinical laboratories, blood banks, and blood bank depositories and authorized the department to inspect them. It appropriated $30,000 therefor. Senate Bill 1104 created a commission to survey and study clinical laboratories, blood banks, and blood bank depositories and appropriated $10,000 therefor.

The responsibility for registration was assigned to the Bureau of Laboratory Evaluation in the Division of Laboratories. For years, the bureau had been engaged in a voluntary program to improve and standardize medical diagnostic work in hospital, clinic, commercial, and private laboratories throughout the state. Herbert E. McDaniels, Ph. D., was chief of the bureau at this time (fiscal year 1962) and had been a department employee since 1930.

From registration of laboratories and blood banks, the legislature moved to licensure. The 74th General Assembly passed, and Governor Kerner approved, on August 23, 1965, the Illinois Blood Bank Act (H.B.1142) and the Illinois Clinical Laboratory Act (H.B.1143). Both acts required licensure of these facilities by the department; provided for advisory boards for each; and appropriated $100,000 for the administration of each. Both were assigned to the Bureau of Laboratory Evaluation. The acts were to become effective on January 1, 1966. However, both laws provided for an allowable 180 days extension for license application. This fact, coupled with administra-

tive problems in getting ready, precluded the issuance of any licenses during fiscal year 1966.

For hospital and independent laboratories, licensure was compulsory. For all other laboratories, inclusion in the program was voluntary.

Both programs included a combination of on-site surveys, proficiency testing, review of personnel qualifications, and educational efforts in the form of seminars, workshops, and manuals. The data collected from clinical laboratories and blood banks were stored in the Springfield computer—a first step in transferring the administrative aspects of the two licensing programs from Chicago to Springfield.

Doctor McDaniels, chief of the Bureau of Laboratory Evaluation, retired in 1966, and Robert G. Martinek, Pharm. D., was appointed in his place.

Effective September 1, 1968, the administration of both the Clinical Laboratory Act and the Blood Bank Act was transferred to the Division of Health Care Facilities and Chronic Illness. The technical and proficiency testing aspects remained in the Bureau of Laboratory Evaluation. This bureau was made responsible for providing consultive assistance to the division in its administration of the federal Medicare and Clinical Laboratory Improvement Act.

By 1969, 280 Illinois-based laboratories, 24 out-of-state laboratories, 14 blood banks, and eight blood bank drawing stations had been licensed. Also, there were 558 participants in the proficiency testing function.

The 1970 reorganization of the department resulted in the establishment of a section called the Hospital and Laboratory Section in the Division of Health Facilities of the Bureau of Personal and Community Health. This section was assigned the hospital, blood bank, and laboratory licensing programs, as well as Medicaid certification responsibilities.

On October 1, 1972, the governor approved House Bill 4445, the "Blood Labeling Act." The purpose of this act was to require that all blood for transfusion purposes must be labeled as to its source—volunteer or purchased—with regulations for the utilization of purchased blood after July 1, 1973. This legislation was brought about largely because of adverse consequences resulting frequently from the use of purchased blood. Purchased blood carried the stigma of a "skid row" source wherein blood was sold for purposes other than altruism. This legislation, in addition to the experience and the advice of the advisory board, prompted the department to prepare regulations pertaining to hepatitis-associated antigen. These regulations were mailed to all independent laboratories. All licensed blood

banks and all hospitals throughout the state were notified of the department's recommendation "that all donor blood shall be tested for hepatitis-associated antigen using techniques specified by the Division of Biologic Standards of the National Institutes of Health."

Governor Ogilvie showed great interest in advancing the availability of volunteer blood and called upon Doctor Yoder to exhort state employees to the cause and to set an example for the rest of the state. State employees pledging to volunteer blood when called upon became members of the "First Illinois Volunteers." The response was startling, something over 40 percent of the state employees pledged to volunteer blood. This precedent was not lost upon the citizens of Illinois, whose response accelerated appreciably from then on. Thousands responded during the Voluntary Blood Donor Week that followed.

From statistical data collected in 1977, Illinois was 99.1 percent reliant on a volunteer blood supply, which set a national precedent. Because packed red blood cells component therapy (packed red blood cells include red blood cells, platelets, and white blood cells) is better transfusion therapy, the department has actively recommended that physicians used packed cells in preference to whole blood, which is more likely to cause adverse side affects. Use of whole blood therapy has been reduced from 78 to 50 percent.

On December 30, 1974, Governor Walker signed into law an act allowing seventeen-year-olds to donate blood. The previous minimum age for blood donors was eighteen. According to census estimates at the time, there were 6,324,000 persons in Illinois between the ages of eighteen and sixty-six. By adding 225,000 seventeen-year-olds to this pool of potential blood donors, there was created a cushion of potential donors to replace those who continuously exceed the eligible age or fail to meet medical requirements. Donors must be in good physical health and must never have had hepatitis.

Chapter 7

EMERGENCY MEDICAL SERVICES AND HIGHWAY SAFETY

Although the department conducted no program by this name until 1970, certain activities dealing with emergency situations were carried out before that date.

Since 1970, this function has been known both as Emergency Medical Services and Emergency Health Services. The latter, used less frequently, is obviously the broader in connotation and probably the more correct since the program involves substantial numbers of disciplines in addition to the medical.

Care of the Critically Injured Patient—In early 1970, concern for the soaring death rate among accident victims prompted state government to undertake the coordination of community resources to decrease the risk of accidents, improve the quality of care for the injured, and implement a plan of emergency medical care for all citizens.

As a result, a plan for the care of the critically injured patient was developed in December, 1970, by the Office of Comprehensive State Health Planning; and, in January, 1971, a governor's committee was formed to guide and assist in the development and implementation of an emergency medical care program. The committee was composed of members of municipal and state governmental agencies, voluntary and private organizations, and professional groups. The initial trauma program was based on the concept of functional categorization of one major clinical category of emergent disease, the critically injured patient.

During fiscal year 1971, plans were made to regionalize all emergency medical services and to institute an integrated (accident to ultimate care) delivery system. Most significant of these developments was the trauma center concept. This proposal provided for the designation of forty trauma centers throughout the state, divided

into three categories of medical care capability—local, areawide, and regional. Twenty-four-hour physician coverage and complete emergency room facilities at the local level was proposed. Patients requiring minimal care were to be kept at the local level, while those more seriously injured were to be moved to an areawide trauma center where more medical expertise and clinical capability would be available. Special regional centers were also designated for state or regionwide use for specific, unique clinical problems, i.e., spinal cord injury, burns, and head trauma. Patients requiring the most advanced techniques for life saving were referred to these facilities, which were to have teaching and clinical research capabilities so that special techniques could be taught to physicians and trauma nurses.

After careful study and planning, the Division of Emergency Medical Services and Highway Safety was established in the department effective July, 1971. The Department of Public Health was charged with the responsibility of developing and administering comprehensive, systematic medical and allied medical programs to meet the challenge of highway safety and injury reduction.

Governor Ogilvie appointed David R. Boyd, M.D.C.M., an instructor in surgery at the University of Illinois Medical School and Cook County Hospital, to coordinate the emergency care program.

Funding for the first fiscal year was provided by the Highway Safety Fund, which the federal government reimbursed on a 50 percent basis. The budget for that year was $1,097,000.

A trauma coordinator was assigned to each center. The responsibility of that position was the coordination of all resources dealing with the critically injured patient. Most of these coordinators were military veterans, trained and experienced in triage of injured patients. As each regional center was established, a trauma nurse position was activated to assist the hospital in upgrading nurse training in the emergency room. The total number of nurses trained during this year was 116.

At all levels of trauma centers, training programs were established for patient care delivery personnel. Over 800 personnel were graduated and certified through the National Registry, with Illinois leading the nation that year in training and certification of emergency medical technicians–ambulance (EMT–A). Also, during the year, over 12,000 patients were admitted through the trauma center complex. Twenty hospital radios were procured and installed.

In July, 1972, a $4,000,000 three-year demonstration contract was awarded to the department by the U.S. Department of Health, Education, and Welfare, to expand the trauma care system to all

categories of emergent problems (acute cardiac, high-risk infant, poisoning, alcohol and drug overdose, and psychiatric emergencies). Through this contractual funding, a total emergency medical services system was implemented, including the subsystems of hospital categorization, communications, transportation, training and education of emergency medical services workers, public education, and evaluation.

Also, during fiscal year 1973, eight more trauma centers were designated, bringing the total to 38; 2,250 EMT–As were trained, bringing the total to 3,050; 74 nurses were trained in the care of the critically ill and injured, bringing the total trained to 190; two mobile intensive care programs were approved in accordance with P.A. 77–2295; and a manual, *Medical Emergency Communications in Illinois (M.E.R.C.I.,)*, was distributed to all hospitals and related providers.

By March of 1974, forty-two trauma centers had been designated. The program had now expanded to include emergency care for heart patients, high-risk mothers and infants, burn victims, acute poisoning, drug overdoses, alcoholism, and psychiatric crises.

Poison Control Program—The poison control program was started in 1953 at Mercy Hospital in Chicago, followed by St. John's Hospital in Springfield being designated a poison control center by the American Academy of Pediatrics through its Illinois chapter. This led to the creation, on July 1, 1956, of a unit within the department to conduct a statewide program of poison control.

From that date, any hospital with adequate facilities that agreed to report cases could be designated by the department as a poison control center. To enlist such cooperation, each center was provided by the department with pertinent references, including a list of some 250,000 toxic or hazardous substances, identified by trade name and the antidote for each.

In 1959, the Illinois Uniform Hazardous Substances law was enacted to supplement the poison control program and its administration was placed in the department. This brought about the establishment of the Bureau of Hazardous Substances and Poison Control in the Division of Preventive Medicine, with the following major responsibilities:

1. administration and enforcement of the Uniform Hazardous Substances Labeling Act and administration of the Program for the Prevention of Accidental Poisoning in Children
2. collection, tabulation, and analysis of case reports and epidemiological reports on accidental poisoning in children and reports

on violations of labeling requirements under the Hazardous Substances Labeling Act
3. compilation and distribution of poisoning statistics through monthly and special reports concerning specific hazardous substances
4. cooperation with national poison control and labeling programs
5. consultive services to industry concerning proper labeling of products deemed hazardous
6. procurement and distribution of reference materials for operation of poison control centers that provide prevention and treatment of accidental poisoning
7. referral of poisoning cases for investigation
8. consultation to local health offices and poison control centers
9. education of parents, especially concerning availability of poisonous substances to children

By July 1, 1962, there were seventy downstate and ten Chicago centers reporting more than 9,000 cases of accidental poisonings among children. Of these reported cases, 97 percent were children five years of age and under, with the one to three year age group accounting for most of the cases. Internal medicines ranked first among the substances accounting for accidental poisonings, with aspirin being responsible for about one-third of all reported cases. Household preparations ranked second, pesticides third, and petroleum distillates ranked fourth.

By fiscal year 1966, ninety-two poison control centers had been established in Illinois hospitals. Noticeable for the first time, in substantial numbers, were the cases of lead poisoning—199 (all from Chicago).

In subsequent years, the number of reported poisoning cases hovered around 12,000 annually, with lead poisoning cases reaching 742 in fiscal year 1969. An apparent increase in poisonings from pesticides was also noted. During that fiscal year, the department began an educational program with industry to provide safety closures on hazardous substances; initiated a program with physicians and parents for the maintenance of a supply of syrup of ipecac in the home; and issued its first protocol on psychedelic drugs.

By fiscal year 1971, the number of poison control centers had risen to 102.

The Illinois Poison Prevention Packaging Act (H.B.1781) passed the general assembly and was approved by the governor on August 2, 1972. Responsibility for administering this law was assigned to the environmental unit of the department.

The program of poison control centers obviously was not one that

could be classified as related to a specific disease; so, in 1976, it was transferred to the Division of Emergency Medical Services and Highway Safety.

Poisoning had been identified at the federal level as one of the six clinical categories of emergent conditions for which a systematic emergency medical service approach could have a significant impact on reduction of mortality and morbidity. In order to integrate poison treatment into the existing emergency medical services system and to provide optimum response, hospital categorization criteria for two levels of poison care capability were developed: local poison treatment centers and regional poison resource centers.

Through the Areawide Hospital Emergency Services Committee, hospitals throughout Illinois have categorized themselves, resulting in the designation of fifty-five poison treatment centers and three regional poison resource centers. Once the treatment system is fully operational, poison prevention will be the program's first priority. One of the three regional poison resource centers was established at St. John's Hospital in Springfield in December, 1977. The other two will be located in Chicago and Peoria.

Special Programs

The Implied Consent Bill (H.B.245)—This bill was passed in the fall session of the 77th General Assembly. This bill required a driver to take a breath test, administered by law enforcement officers pursuant to lawful arrest, to determine blood-alcohol content. It is interesting to note that the blood-alcohol study conducted by the department was among the first of the few such studies in the nation. Illinois, however, was the last state to adopt an "implied consent" law. This law became effective July 1, 1972.

Governor Ogilvie appointed Doctor Boyd as chairman of the Governor's Task Force on Implementation of Implied Consent, and administration of the law was placed in the Division of Emergency Medical Services and Highway Safety. The activity remained in this division until 1977 when it was transferred to the Division of Laboratories. The Implied Consent Program is more fully described in the chapter, "Special Programs, Projects, and Services."

Emergency Health Preparedness Program—This program was transferred in August of 1972 from the Division of Local Health Administration to the Division of Emergency Medical Services and Highway Safety. It was responsible for training adults and public school students in "medical self-help," and was the most successful

of similar programs among all the states in this training endeavor. This activity ceased to function in 1974.

Mobile Intensive Care Unit Program—This program is an important segment within the system of total emergency care. Although a system was developed in the Chicago area in 1972, there were no approved mobile intensive care unit (MICU) systems downstate until passage of the paramedic law in December, 1974. The purpose of the MICU program is to provide an advanced level of prehospital life-support capabilities at the scene and en route to a hospital.

In 1976, there were thirteen approved MICU programs in the Chicago area and four downstate. In 1977, additional programs, especially downstate, were considered necessary and were being promoted.

Rape Victim's Emergency Treatment Act—This act, approved by the governor in August, 1975, required the standardization of procedures to be followed in all Illinois hospital emergency rooms in the treatment of rape cases. Prior to this legislation, there were great disparities in the emergency treatment offered by hospitals, with some declining to provide treatment of any type to victims of sexual assault.

Under the new law, all hospitals licensed by the department that provide general medicine and surgical services must also provide specific emergency services to victims of sexual assault. By 1977, nearly 100 hospitals throughout Illinois had been approved by the department as rape treatment centers.

Miscellaneous program responsibilities, assigned to the Division of Emergency Medical Services and Highway Safety, have included the provision of medical coverage for visitors to the Illinois State Fair and the supervision of the state-operated first aid stations.

Organizational Placement Within the Illinois Department of Public Health

The Division of Emergency Medical Services and Highway Safety was organizationally placed in the Bureau of Personal and Community Health during the Yoder administration. With the Lashof reorganization of August 16, 1973, it became one of four major bureaus comprising the department's basic organizational structure. Another reorganization on December 14, 1973, made it a division within the Office of Health Services and Local Health Administration.

Doctor Boyd resigned to take a similar job on the federal level and,

on September 1, 1976, he was replaced by Mohammed Akhter, M.B.B.S.

Progress in establishing and advancing emergency health services in Illinois has been remarkable. This state has been a leader in this area of services, and advancements and refinements continue to accelerate the saving of life in emergency situations.

Chapter 8

SPECIAL PROGRAMS, PROJECTS, AND SERVICES

This section deals with various functions and activities that do not fit precisely into any of the foregoing major headings. They vary in classification from direct public health services to health-oriented activities. In some cases their placement in the Department of Public Health might even be questionable. However, in recent years, the concept of public health has broadened substantially from the limited definitions of a few years ago. Its absorption of some of the following functions is proof of the viability of the public health service in this state and its dedication to the betterment of living for Illinois citizens. In every instance, each of the following functions was placed in what was considered the most logical unit of the department organization or into a new unit especially created.

Sickle Cell Anemia

Sickle cell anemia is a hereditary form of chronic hemolytic anemia characterized clinically by symptoms of severe anemia, jaundice, recurrent attacks of severe pain, increased susceptibility to certain infections, decreased physical capabilities, hemophilia or other neurological disturbances, and, frequently, a shortened life span. It is genetic in origin and can be transmitted only from parent to child. It is not contagious and affects almost exclusively the black population.

On June 13 and 14, 1973, the department and the State of Illinois Sickle Cell Commission sponsored a seminar on genetics information and counseling techniques in sickle cell programs at the University of Illinois Medical Center Campus. Prior to this, when the Chicago State Tuberculosis Sanatorium was being converted to the Department of Public Health Hospital and Clinics, space was made

available therein to the University of Illinois for a sickle cell center. This center, one of fifteen throughout the nation at that time, provided comprehensive services to patients with sickle cell disorders, and conducted research, screening, counseling, education, training, and public and professional information programs.

On July 15, 1973, the department initiated a new service that provides blood tests for sickle cell and other blood diseases. This laboratory program is offered primarily to clinics involved with health care for indigent local populations.

Veterinary Public Health

When Doctor Yoder came to the directorship, veterinary public health activities were in the Division of Milk Control and Veterinary Public Health. In 1963, he transferred the veterinary function to the Division of Preventive Medicine as a section in the Bureau of Epidemiology.

The responsibilities of the section included surveillance, investigation, and implementation of measures to control zoonotic diseases—those diseases transmitted from animal to man.

The program was divided into four main phases: (1) consultation provided by a well qualified doctor of veterinary medicine with a degree in public health, (2) surveillance, (3) case investigation, and (4) special studies.

Included in the consultation service was the development of local control programs as well as preparation and distribution of professional and public educational materials. In addition to its concern with the zoonotic diseases, the section has continuously, since 1963, provided depth and professional epidemiological capability to the total communicable disease control program.

Major activities from 1962 to 1973 included increased surveillance of cases of animal rabies with special attention to those situations where rabid animals exposed humans, resulting in the administration of rabies vaccine.

A study initiated in 1967 continues to supply information concerning the circumstances surrounding the administration of rabies vaccine to Illinois residents.

In 1971, the Veterinary Public Health Section, in cooperation with other state agencies, the Illinois State Veterinary Medical Association, and Illinois dog clubs, was instrumental in obtaining enactment of the "Animal Control Act." This act provided for stray-animal control and impoundment, rabies vaccination, animal-bite investigation, and educational measures for the public.

A major outbreak of brucellosis in 1966 in a central Illinois packing plant was investigated. The plant had experienced thirteen human clinical cases in the previous two-and-one-half years. Blood samples were obtained from 551 of the 783 employees which showed a reactor rate of 13 percent.

An in-depth, perspective, five-year field study (1964 through 1968) assisted in delineation of the epidemiology of leptospirosis in Illinois. This involved collection of specimens from domestic and wild animals and an analysis of climatological data.

The section was also involved in investigating the St. Louis encephalitis outbreaks of 1964 and 1968 and the epidemic of 1975.

In 1960, the University of Illinois Board of Trustees founded the Illinois Center for Zoonoses Research within the College of Veterinary Medicine on the Champaign campus. The center (CZR) was established to advance research efforts in the zoonoses and comparative medicine. Doctor Yoder was appointed to the faculty in a lecture capacity, and the veterinary public health staff served as active participants in the work of the center, especially in a field capacity.

Initial activities emphasized arboviral research in southern Illinois. Later efforts were directed toward cancer research, especially in the area of investigation, to further delineate the role of viruses in cancer development.

Though still in existence, activities at the center have been somewhat deemphasized since 1968 when higher priorities were allotted to other programs.

At the time of its establishment, the center was only the second of its kind in the world.

For most of the period covered by this report, J. Russell Martin, D.V.M., M.P.H., headed the Veterinary Public Health Section and, in 1972, became head of the Communicable Disease Program in the capacity of an epidemiologist.

Nursing

This departmental activity concerns itself with the entire field of the nursing profession with emphasis on the public health nursing phases. The objectives have been to provide nursing representation in the development of department policies and programs; to represent and speak for public health in state nursing organizations and for nursing education planning; to participate in the formation of appropriate agency structure to provide public health nursing services; to improve the basic education of both registered and practical

nurses and the graduate preparation in the specialties, particularly public health; to provide the necessary nursing services required by the various medically oriented programs of the department; to establish and promote the use of nursing standards to improve nursing performance; to expand the availability of public health nursing services through recruitment; to provide consultation to local public health nurses; and to develop and administer special nursing projects.

To give direction and guidance to these activities, as well as technical supervision, a special unit long existed in the department's organizational pattern, staffed by a chief public health nurse and nursing assistants.

The actual placement of the public health nursing unit in the organization has been changed a number of times, which accounts in part for its activities being presented under "Special Programs, Projects, and Services." None of the locations within the hierarchy has proven ideal or even satisfactory in implementing all the nursing objectives. Despite the problem of unresolved organizational placement, strong nursing convictions and leadership have contributed to the success and accomplishments of the public health nursing services.

Assessment of Local Nursing Services—In 1961, the public health nursing unit (then called the Bureau of Nursing in the Division of General Administration) completed a four-year effort to promulgate "Minimum Standards for Nursing Services in Local Health Departments." Concurrently, a "Guide for a Comprehensive Model Nursing Service" was developed. This was immediately followed by preliminary assessments of nursing services being provided by local health departments. Needs and problems were identified as follows: (1) a well-qualified nursing supervisor or director was lacking in many cases, and eleven vacancies existed at the time; (2) an inadequate budget for nursing services existed in most agencies; (3) a majority of staff nurses were inadequately prepared academically as public health nurses; (4) a limited understanding of the concept of a family-centered nursing service existed; and (5) when too few nurses were employed to provide a comprehensive nursing service, emphasis was usually on the school-age population while maternal and child health and adult health, for example, received perfunctory attention.

These assessments of the nursing services in local health agencies were, during the next year, followed up by consultations with local health officers and program directors to determine ways and means of strengthening and improving nursing services. It was stressed

that the granting of state and federal funds required more careful assessment of objectives, programs, and results.

At the same time, the Bureau of Nursing turned its attention to the seventy-two counties that did not have full-time health departments.

There were constant difficulties in providing nursing services to these counties. The nursing services emanating from the department's regional offices were designed primarily to provide consultation rather than direct service and were necessarily limited (with some exceptions) by the availability of funds. Many counties and local agencies, recognizing certain needs only, were employing nurses in increasing numbers to serve special age groups or to cope with special diseases such as chronic illnesses. Recognizing the limitations of such a trend, the Bureau of Nursing increased its efforts toward the establishment of health departments in these seventy-two counties.

Nursing Surveys—Inasmuch as the expansion and improvement of public health nursing in Illinois was a major objective of the department, the bureau carried out various studies and surveys to determine numbers and trends in the employment of nurses in public health. In 1962, it was found that 1,694 nurses were employed in 517 agencies. Of these, 563 nurses were in official local health agencies, 310 in voluntary agencies (mostly visiting nurse services), 715 in boards of education, 51 in state agencies (Illinois Services for Crippled Children and the Department of Public Health), and 49 in combination nursing services. The latter is a service jointly supported by tax funds, fees for nursing services, community funds, gifts, and contracts with other agencies.

By January 1, 1964, another census of nurses was completed which showed that 1,725 nurses were employed. Of these, 543 were in official local health agencies, 743 in boards of education, 320 in voluntary agencies, and 70 in combination nursing services. These results were disappointing, since they revealed an increase in nursing employment in all areas except local public health agencies which showed a loss of 20.

The census of January, 1966 had 1,659 nurses reporting, of which 37 percent had a baccalaureate or more advanced degree. Of the total 1,659 reporting, 241 held administrative positions and 1,418 held staff positions. Within the administrative group, 65.6 percent held baccalaureate or higher degrees, while the staff group showed 32.4 percent with such degrees. At that time, it was determined that Illinois ranked 34th among the states and territories in the level of preparation of nurses in administrative positions and

21st for nurses in staff positions. The census did, however, reflect some encouraging figures relating to the employment of graduates of collegiate basic nursing programs, all of which included preparation in public health nursing. There were 142 such graduates employed in 1966 as compared with 64 in 1964.

In 1965, the Illinois Study Commission on Nursing was created by the Illinois League for Nursing and the Illinois Nurses' Association, acting through a coordinating council. The staff of the Bureau of Nursing participated actively, especially as members of the Community Nursing Committee, one of the seven standing committees. The commission completed its formal study in March, 1968, with a public meeting to launch the commission report. The report contained fifty-four major recommendations, and each was assigned for implementation to appropriate agencies. Eleven of the fifty-four recommendations were assigned to the department as the agency most responsible for implementation. In addition, the recommendations of the committees on institutional nursing, occupational health nursing, and mental health nursing were all related to the concerns of the department. For example, as revisions were made in the rules of such departmental programs as licensure of hospitals, nursing homes and homes for the aged, consideration could be given to the recommendations of the committee on institutional nursing for upgrading the quality of nursing services.

Some quotes from the report will provide insight as to the public health nursing and community health situation at the time from a nursing viewpoint.

Item X states: "Comprehensive health planning (Public Law 89–749) and the Regional Medical Program (Public Law 89–239) are presently being implemented in Illinois. . . . It is apparent that in health facilities and other health planning activities in Illinois to date, nursing has often not been included nor has it always shown interest. . . . In public health nursing, the very future of this specialty seems to hinge on whether the nurse's role is defined and understood and whether her full potential is realized in the comprehensive community health services that are now developing." And recommendation number 30 states: "That the State Department of Public Health, in its future administration of Public Law 89–749, make its approval of the development of new facilities and community health services contingent upon a demonstration by the sponsors of a reasonable capacity to staff them; also, that it actively promote the consolidation of specialized institutional and community health services by area or community as a means of promoting more effective use of the present limited supply of R.N.'s."

Item XI of the report goes on: "The field of Public Health, and its nursing component, has not been growing or thriving in Illinois. Illinois has been and still is far below the national average in what its taxpayers have been willing to invest in local health services. . . . In these services, nursing has not had a well defined role. The State Department of Public Health has not been structured to give overall professional direction and leadership to these nursing services. Local health services are poorly coordinated."

The following are some of the recommendations that were directed to the department:

#32. "That the Illinois Department of Public Health be urged to create a Division of Nursing, the director of which should be qualified and authorized to direct all nursing services of a department charged with providing leadership and consultation to community nursing services across the state."

#36. "That the Department of Public Health be encouraged to provide the needed financing for continuing education programs for community health nurses."

The problems surrounding recommendation number 32 were briefly discussed above, while recommendation number 36 proved somewhat disconcerting to the director and his administrative staff since the departmental training program had been allotting the lion's share of its available training funds to nurse training.

Recommendation number 35 was most significant. It stated "That the University of Illinois College of Nursing be encouraged to implement at an early date its plan for a master's program in public health nursing."

In 1968, shortly after receiving the report, Doctor Yoder and Mrs. Pearl Ahrenkiel, the chief public health nurse, documented the needs for better prepared nursing supervisors and administrators and requested the University of Illinois College of Nursing to establish a master's program in public health nursing at the earliest possible time. This support enabled the college of nursing to secure approval for the master's program to which students were admitted in 1970.

Unquestionably, the "Nursing in Illinois" report stands as a significant accomplishment providing most comprehensive coverage and guidance for achieving adequate and quality nursing services to meet the needs of the 1980s.

First Aid Stations—In 1961, the department operated two first aid stations under the supervision of the Bureau of Nursing, with medical guidance from the Division of Preventive Medicine and the

Sangamon County Medical Society. They were located in the State Capitol Building and the State Office Building. These were each staffed by a registered nurse. First aid services were provided to state employees, visitors to the state complex, workmen, and members of the general assembly. Statistics available for fiscal year 1965 showed that over 7,000 services were provided, of which 6,187 were services to elected officials and state employees.

A third first aid station was established in Chicago during fiscal year 1967. This station was located in the State of Illinois Building to serve the same type of clientele as the Springfield stations. Then, in fiscal year 1969, a fourth first aid station was established in the Department of Transportation building in Springfield. This was done to serve those state employees working a long distance away from the state complex. In that year, 11,083 persons were served by these stations. This number increased to 12,700 in fiscal year 1970; 13,850 in fiscal year 1971; 15,667 in fiscal year 1972; and 16,000 in fiscal year 1973. In 1973, responsibility for operation of the first aid stations was transferred to the relatively new Division of Emergency Medical Services and Highway Safety for a short period. By 1977 the first aid stations were directed by various state agencies, such as the Secretary of State and the Department of Transportation.

Training and Education—Although the departmental training program is discussed elsewhere, the Bureau of Nursing has been one of the most energetic units in promoting educational opportunities. Complete documentation of the bureau's efforts in this area cannot be ascertained, so only a few of its major efforts are included herein. These, however, demonstrate sufficiently the department's interest in nursing education.

Revocation of the Public Health Nursing Act of 1931 was signed into law on August 8, 1961, because the fifteen hours of educational requirements defined in the law were no longer available or practicable. Preparation for public health nursing—theory and field practice—had become a part of a four-year basic collegiate nursing program or a degree-completion program for graduates of diploma schools of nursing. An unexpected by-product of this revocation was the removal of school nurses from the Teachers' Retirement System. This oversight was corrected in the 1963 legislative session and was made retroactive.

In fiscal year 1964, the Bureau of Nursing succeeded in obtaining chronic illness funds to send 128 nurses to a rehabilitation nursing course, recruiting them from hospitals, nursing homes, visiting nurse services, and local health departments. That same year, seven applicants were funded for the final year of a basic collegiate nursing

program with the provision that they would accept employment in a local health department upon completion of their program of study.

In 1965 and 1966, the bureau nurses worked with the public health nursing faculties of the University of Illinois and other collegiate schools of nursing in planning, developing, and conducting eight workshops for supervising nurses and thirteen workshops for staff nurses. All of the nurses attending were from newly organized health departments and were not considered to be prepared educationally for their assignments.

This program continued in fiscal year 1968, with 118 staff nurses attending four eight-day sessions, and 35 supervising nurses attending a five-day session. The program, however, was not only for nurses new to public health but also for nurses in visiting nurse associations and nurses in maternal and child health services. One of its purposes was to encourage agencies with limited services to expand their nursing programs to include services in maternal and child health.

During the same year, 138 nurses from hospitals, nursing homes, and home-health agencies were recruited and funded to attend a three-week course in rehabilitation nursing at the Institute of Physical Medicine and Rehabilitation in Peoria and the Schwab Rehabilitation Center in Chicago. This program was continued in fiscal year 1969, with 145 nurses attending these courses under department sponsorship. In addition, seventy-seven nurses were recruited and subsidized for attending the coronary care workshop at Loyola University in Chicago.

Fiscal year 1969 was also the fourth year of a departmental contract with the University of Illinois College of Nursing for conducting nurses' workshops in community health and home-health agencies. As an example of the number of nurses given training through this effort, 192 were enrolled in a series of sixteen one-day sessions and a series of seven one-day sessions in fiscal year 1970, and 57 were enrolled in an intensive four-week course in cardiovascular nursing.

Similar efforts to recruit nurses for public health and to upgrade the quality of all aspects of nursing care continued at about the same level as detailed above during the remainder of the Yoder administration. An entirely new nursing service philosophy was effected by Doctor Lashof (which will be commented upon in later pages), which resulted in shifting most nurse training to program units of the department.

Home Health Services—During fiscal year 1966, changes made in the Social Security Act were of major concern to the nursing

service. Title 18 of Public Law 89–97 (Social Security Act), concerning health insurance for the aged (Medicare), focused on the provision of a broad array of services to persons over sixty-five years of age. This included home-health services, defined as "skilled nursing services in the home plus one additional therapeutic service"—such as physical therapy, speech therapy, occupational therapy, social work, or nutritional assistance.

A major problem facing the department was the lack of organizational structure locally to provide these home health services. Sixteen counties had countywide coverage for home nursing but few had a second therapeutic service; another eighteen counties had a health department but did not provide home nursing except for demonstration purposes or for exceedingly limited periods; another nine counties had a visiting nurse service (care of the sick at home) covering portions of each county; the remaining 59 counties had neither a health department nor a visiting nurse service.

Thus the department faced a major task in attempting to accomplish home-health coverage before the law became effective on July 1, 1966.

Approximately $312,000 in federal funds was available for the development of home health services in Illinois. After considerable planning by a so-called Medicare Committee consisting of representatives from the Division of Hospitals and Chronic Illness (where other phases of the Medicare program had been placed administratively), the Division of Local Health Services, the Division of Preventive Medicine, and the Bureau of Nursing, steps were taken to alert local interests to the change in the law. County medical societies, boards of health, boards of supervisors, visiting nurse associations, and others with a possible health interest or responsibility were alerted. Concurrently, the changing role of the nursing unit in each regional office was studied and clarified in relation to home health services.

Beginning in November, 1965, a team from the Division of Local Health Services, the Bureau of Nursing, and the regional offices met with sixty-eight county boards of supervisors from one to five times each to discuss needs, problems, resources, and approaches to provide home-health services.

A facet of Illinois law that the department seized upon was the authority of county boards of supervisors to establish county health departments by resolution of the board. Although this method of establishment provided no earmarked tax funds for support, it did provide the basic structure to accommodate home health services

and permitted the use of county general funds if the board saw fit to allocate any for this purpose.

Thirty-two county boards of supervisors had established resolution health departments by July 1, 1966. Not all did so willingly or with enthusiasm. Many were pushed to action by the possible reaction of senior citizens who might resent the withholding of these services to which they were entitled.

From January 1 to July 1, 1966, the department teams met with newly appointed boards of health to interpret the county health department law, to help in the development of budgets and services, and to locate nursing staff and those professionals to provide the second "skilled service." More than 130 consultive visits were made to these newly created agencies and to existing health departments that would be adding home health services. In addition, visits were made to hospitals, county nursing groups, medical societies, and any other potential providers of home health services.

It was a period of strenuous and cooperative effort. The administrative procedure of recommending interim certification of 71 home health agencies was completed before July 1, 1966, and the beginning of Medicare services.

Among the seventy-one certified agencies were twenty-two new health departments without experience in providing service. Many health departments, established previously, offered home health services for the first time. Visiting nurse agencies were in the strongest position—having long been established as providers of nursing care in the home and being well-known and highly respected by physicians, hospitals, and local families.

Within six months, most agencies were receiving some requests for home-health services; a few were experiencing sufficient demand to make additional staff necessary; and very few had only a limited number of referrals.

By the end of the first year of operation, fourteen more agencies had been certified and two had been discontinued as home-health service agencies. By far the most complex area in the state was the Chicago–Cook County area where eighteen separate agencies were certified. The Cook County Department of Public Health, with the sanction of its board of commissioners, was serving all areas of the county not served by another agency—a stupendous and noteworthy undertaking.

Securing the second therapeutic service proved to be a difficult task for most home-health agencies.

The responsibilities accruing to the entire nursing staff of the

department—bureau and regional—required effort and hours beyond any previous call to duty. Sixteen-hour days were not unknown in providing assistance to boards of health and to visiting nurse associations in developing or revising agency policies, in helping with recruitment, in orienting and guiding new nursing staff, in providing in-service education, in helping with cost analyses, and in assessing local performance against standards set by the Social Security Administration. Blue Cross served as the fiscal intermediary in Illinois.

By fiscal year 1968, only slight additional progress had been made in achieving statewide coverage for home-health services certified under the Medicare program. The Clay, Monroe, and Greene County Health Departments were approaching certification, as well as one hospital in Iroquois County and one in Jefferson County. In that year, there were still thirty-nine counties that lacked an organizational structure for providing home-health services.

In fiscal year 1969, five new home-health agencies were certified, bringing the state total to eighty-eight agencies providing visits to sick or disabled persons in their own homes. During the following year, these were resurveyed, and recertification was recommended to the Social Security Administration. The nursing staff also assisted home-health agencies in a large number of cases where claims for nursing care had been rejected by the Bureau of Health Insurance of the Social Security Administration.

The home-health service activity continued to be a major nursing effort until 1974. Organization changes at that time left the responsibility primarily with the regional nurses.

Coordination With Mental Health—In fiscal year 1963, the department adopted a policy of establishing closer working relationships with the Department of Mental Health for better coordination of services provided at the community level. Nursing services especially were emphasized.

During the following year, there was a marked acceleration in thinking and planning between the two departments involving local medical health officers, local nursing directors, heads of department programs and personnel from the emerging mental health zone centers of the Department of Mental Health. Public health nurses had long participated in casefinding of mental health problems and in helping patients and their families to secure care. This new cooperative effort focused on the growing need for follow-up of patients from the zone centers as they returned to their families and communities.

During 1964 and 1965, the Department of Mental Health, the Bureau of Nursing, and the Bureau of Maternal and Child Health carried out a study of the needs of 1,700 children on the waiting list for admission to the Dixon and Lincoln state schools for the retarded. The results provided new insights in long-range planning for the mentally retarded.

Further involvement of department nurses in mental health problems came about when private psychiatric hospitals, previously licensed by the Department of Mental Health, were transferred to the Department of Public Health for licensure.

Regional and local public health nurses continue their awareness of mental health problems and needs, and have, since the beginning of this coordinated effort, provided a valuable and productive service to Illinois families.

Continuity of Care—The Bureau of Nursing, always patient–oriented, had long been disturbed by the absence of accompanying information when a patient was transferred from one health-care facility to another. It therefore undertook a project in 1966, the goal of which was a continuum of quality care for the patient. The project was developed in Sangamon County (with a countywide visiting nurse association) and in Menard County (with a health department providing home health services). In the two-county area, there were two general hospitals, a county tuberculosis sanatorium, nineteen nursing homes, six sheltered care homes, and four homes for the aged. Each participating agency or facility contributed toward the financing of the project, augmented by some federal funds made available by the Division of Hospitals and Chronic Illness. Shortly after July 1, 1966, the Bureau of Nursing employed a public health nurse to coordinate the project. A "transfer of information" form was developed and approved by the two county medical societies, and utilization was assured by the agencies and facilities involved.

It soon became evident that there was an increase in the known number and quality of referrals, and greater involvement of physicians in medical care plans and nurses in nursing care plans. The project was proving that the care of the patient could be improved by this type of effort.

The so-called Sangamon–Menard County Continuity of Care Project continued to produce desirable results into fiscal year 1969. Referrals increased from 1,341 in fiscal year 1967 to 2,669 in fiscal year 1969. The project attracted numerous observers from surrounding counties.

In its fifth year of existence, the project continued to show a

marked increase in referrals from hospitals to extended care facilities, nursing homes, sheltered care homes, and St. John's Tuberculosis Sanitarium.

Toward the end of 1972, the Sangamon–Menard County Continuity of Care Project was phased out since it was felt by the director that the demonstration of improved continuity of care had been accomplished.

Pearl Ahrenkiel, R.N., B.S., became chief of the Division of Nursing on August 31, 1956, and served as chief public health nurse of the department until her retirement in 1969. Grace Musselman, R.N., M.P.H., was shortly thereafter appointed acting chief. With the reorganization of 1970, the Bureau of Nursing was renamed the Division of Nursing and transferred to the newly created Bureau of Personal and Community Health. In November of 1970, the acting chief of the nursing unit retired and was replaced by Helen M. Bruening, R.N., M.P.H.

This placement of the nursing service did appear to bring about a closer rapport and to improve working relationships with the medically oriented programs.

The next reorganization, in 1973, resulted in the transfer of nursing personnel, except the chief public health nurse, to specialized programs. This left the Division of Nursing with responsibilities so limited that it ceased to exist as an identifiable unit of the department. The chief public health nurse remained on the job until 1976.

By the fall of 1977, the organizational chart of the department showed no special unit bearing a nursing title or similar visibility of nursing leadership.

Abortions

The department was given the statutory responsibility by the 78th General Assembly of assuring that all surgical procedures, including abortions, are performed under circumstances that insure maximum safety (S.B. 1049, 1050, 1051). While abortion clinics are included under the statutory program, special attention is called to them because of public interest and the department's responsibilities to see that the public health is properly served and satisfied in the performance of abortions. Standards designed to control the environment in which abortions are performed and to protect the health and welfare of the women of this state were passed and implemented. The standards cover abortions at any stage of pregnancy and in hospitals as well as out-of-hospital facilities.

Blood-Alcohol Study

This study was extremely important inasmuch as its results were significant to future legislation and to health and safety programs. It influenced such legislation as "implied consent" for operating a vehicle and set some standards for determining drunken driving.

In 1965, the general assembly authorized a one-year study to determine blood-alcohol levels in vehicular and pedestrian fatalities and appropriated $25,000 therefor. The study was jointly undertaken by the Illinois Department of Public Health, the Illinois State Medical Society, the Governor's Official Traffic Safety Coordinating Committee, and the Illinois Coroners' Association.

The primary purpose of the study was to determine Blood-Alcohol Concentrations (BAC) among drivers, suspected drivers, occupants, and pedestrians involved in motor vehicular fatalities. Fatalities below the age of fifteen, either as pedestrians or occupants, were, for some reason, presumed not to have been drinking and were thus excluded from the study.

In 1966, the general assembly amended the Coroners' Act to place upon county coroners the responsibility for drawing and submitting blood specimens from each traffic accident fatality (as categorized above) within twenty-four hours following the accident and prior to any embalming procedures. Coroners were paid a modest fee for each specimen collected.

All specimens were sent to the toxicological laboratory of the department in Chicago, except for fatalities occurring in Cook County. These were sent to the Cook County Morgue Laboratory, also in Chicago.

Mailing containers and equipment to collect specimens were supplied to all coroners to insure prompt and safe transportation of specimens to the laboratories by police relay, mail, or express. The results of all analyses were sent to the department's Bureau of Epidemiology in Springfield for tabulation and evaluation.

The four seasons of the year 1966 presented a large variety of driving hazards, terrain, and roads. Every fatality, whether urban or rural, was investigated by a coroner or a state or local police officer.

Of 2,206 fatalities, 1,562 blood specimens were submitted for alcohol determinations. Forty-one percent (642) showed measurable blood alcohol levels; 25 percent of drivers had levels over 0.15 percent; and 10 percent had levels from 0.10 to 0.15 percent. In 1965, 0.15 percent was the BAC for presumptive evidence of "driving while intoxicated." Today, it is 0.10 percent.

In the fifteen-to-twenty-year-old driver group, 33 percent had

measurable blood alcohol levels, of which almost 20 percent had over 0.10 percent; 15 percent had over 0.15 percent. Approximately 42 percent of the pedestrians had measurable amounts of alcohol of which 32 percent contained over 0.10 percent.

The study showed the relationship between blood-alcohol levels of over 0.10 percent and motor vehicle fatalities. This appeared to indicate that the legal limit for driving should not be more than 0.10 percent.

The reader interested in greater detail should consult the *Illinois Medical Journal*, May, 1967, from which much of the above was abstracted.

Nutrition

Nutrition education is an important component in the maintenance and promotion of health and, to some extent, in the prevention of disease. Because of its involvement in so many diverse programs of the department, its actual placement in the organizational structure has been varied.

A review of nutrition services emanating from the department reveals that the agency has never had a strong, effective, coordinated nutrition service. The writer, in his early years in administration, recalls the philosophy of the department's policymakers that nutritionists and dietitians employed by the various food industries were sufficiently numerous to preclude stressing this aspect of public health.

Because previous historical documents appear to deal with nutrition education in a rather cavalier manner, it is considered appropriate to present a short review of the nutrition service prior to the time limits set for this volume.

As far back as 1927, the department received an appropriation sufficient to employ a "food specialist" although no record can be found that such a person was ever employed. Also in 1927, the record indicates that the Division of Child Hygiene and Public Health Nursing (which became the Bureau of Maternal and Child Health in August, 1950) conducted a service in "dietary and nutritional education," including a project in breast feeding. No record can be found of how the service operated or what was accomplished.

Probably no more than eight or nine dietitians and/or nutritionists have been employed by the department between 1936 and 1977. The nutritionist with the longest tenure was Miss Leone Pazourek who was employed from October, 1936 to July, 1971. Over this period she provided service to the Division of Maternal and Child

Health, the Division of Hospital Construction and Services, the Bureau of Hospital and Chronic Illness, and the Division of Preventive Medicine. Other nutritionists employed by the department prior to 1967, and more or less supervised by Miss Pazourek, were Louise Moody, Olga Nagel, Anne White, Wilma Robinson, and Faye Paris, on a part-time basis.

When the Division of Nursing was created, Barbara Butz was employed in that unit. About the same time, Michael Salpas was employed as a nutritionist in the Division of Health Facilities.

On July 1, 1971, Genevieve Anthony, a registered dietitian, filled the position vacated by Michael Salpas, and in January, 1973, George Klatt, nutritionist, replaced Barbara Butz, who had resigned her position in the Division of Nursing in August, 1972.

It should not be assumed from the above that only cursory services in the area of nutrition education were forthcoming from the department. Public health nurses, in their daily efforts, exhibited substantial interest in the nutrition of their clients; Doctor Donaldson Rawlings, chief of preventive medicine, consistently stressed nutrition in his capacity as the department's representative on the Illinois School Health Committee; and E. L. Wittenborn, as chief of the Division of Health Education, made sure that the then existent film library maintained numerous films on nutrition. He also became the department representative on the Illinois Nutrition Committee, subsequently becoming the chairman of that committee. A short-lived project, funded by the United States Public Health Service, concerned itself with the nursing follow-up and treatment of men rejected from military service because of physical defects, most common among them being obesity. Also, the Division of Maternal and Child Health assisted in funding the annual meetings of the Illinois Nutrition Committee during the Yoder years.

"Nutrition cannot be divorced from health. Adequate nutrition implies the physiological utilization of essential nutrients in the amounts and in a balance that will promote physical and mental function from preconception to death." This definition formed the rationale for the Ten State Nutrition Survey conducted from 1968 to 1970.

On July 1, 1974, nutritionist Polly Bosdick was employed in the Division of Family Health and assigned to the Women, Infants, and Children's (WIC) federally-funded food program. She, in turn, left the department in October, 1975, and was replaced by Marilyn Snyder on February 15, 1976.

Norma B. Relph, a registered dietitian, joined the dietary services section of the Office of Health Facilities and Quality of Care on

November 10, 1975. The section was, in 1977, supervised by Genevieve Anthony who also functioned as a consultant.

The primary objective of the Dietary Services Program is to maintain and improve the nutritional status of residents in long-term care facilities and patients in acute care facilities. This activity utilizes consultation to such facilities and the provision of training programs for providers, health facilities staffs, and other professionals interested in the nutrition of the elderly. In the period from January 1, 1975, to November 11, 1975, consultation services were provided to 218 facilities serving 17,879 clients, and twenty-four training programs were carried out with a total attendance of 2,132.

The following are basic functions of a public health nutrition program:

A. To determine the nature and magnitude of nutritional needs and establish long-range and short-term program goals.
B. To work toward integration and coordination of the nutrition service with all other appropriate services within the health agency and other related agencies.
C. To provide nutrition education programs that should lead to improved eating habits throughout life and thereby foster the maintenance of health and the prevention of disease.
D. To emphasize nutrition services for groups most susceptible to nutrition deficiencies. These groups would include, but not be limited to—
    1. expectant and nursing mothers
    2. infants and children
    3. adolescents
    4. mature adults
    5. the aged
    6. those with chronic illness
    7. those on limited food budgets
E. To promote programs for adequate food service in institutions by offering consultation and technical assistance to food service and other appropriate personnel, and by participating in the development of licensing standards for food service and standards for other facilities providing food service and/or nutritional care. The institutions could include but not necessarily be limited to—
    1. hospitals
    2. long-term care health facilities (nursing homes, sheltered care homes and homes for the aged)
    3. home health agencies

4. health maintenance organizations
5. child care institutions
6. schools
7. industry

F. To provide consultation services to groups, organizations, and agencies on the development and administration of the nutrition aspects of the programs.

G. To evaluate on a continuing basis the effectiveness of public health nutrition programs.

Unfortunately, the history of the department reflects mediocrity in the provision of nutrition services on a continuous, coordinated, and well-organized basis.

Health Maintenance Organizations

A health maintenance organization is, in effect, an agency wherein its members pay for medical care in set monthly installments.

Among the first health maintenance organizations (HMOs) in Illinois were those established at Lincoln, Illinois, and a community "clinic" type at Carbondale, in the spring and summer of 1971. Insofar as can be determined, they received federal grants from the United States Department of Health, Education and Welfare and were established in accordance with Section 1861 of the Social Security Act.

In 1973, Public Law 93–222 was enacted by the congress. This was "An Act to amend the Public Health Service Act to provide assistance and encouragement for the establishment and expansion of health maintenance organizations, and for other purposes."

In November, 1974, the Illinois Department of Public Aid signed its first Public Aid/HMO contract with the Cure Health Plan. Several problems developed with this contract and the Department of Public Health became involved in the ongoing administration and operation of the program.

In April, 1975, an initial policy and guideline paper was developed by the Departments of Public Health, Public Aid, and Insurance in order to set forth the guidelines and requirements for HMOs seeking agreements with the Department of Public Aid.

The Illinois Health Maintenance Organization Act (P.A. 78–1151) was signed into law by Governor Walker in October, 1975. This law provided that the Departments of Public Health and Insurance jointly regulate the activities of HMOs operating in the state. The Department of Insurance was made responsible for reviewing the business aspects of an HMO plan such as its organizational structure,

contractual agreements and financial solvency. The Department of Public Health was mandated the task of reviewing the health services provided by HMO programs, including the availability, accessibility, utilization, and quality of the services provided. In order to administer and develop such a program, there was established in October, 1975, in the department, under the Office of Health Facilities and Quality of Care, a special section to handle this new responsibility, and a qualified person, Mary Beck, with a master's degree in public health, was employed to supervise it.

All HMO systems were required to apply for a Certificate of Authority by July, 1976, and all programs in existence did apply. This led to an active effort on the part of both departments to evaluate and review these programs.

In July, 1976, the Home Health Agency Section was joined with the HMO Section to form the Division of Ambulatory Care Review. The staff consisted of one division chief, a secretary, an HMO specialist for administrative functions, a nurse coordinator for clinical functions, one staff nurse to assist in ongoing reviews, a nurse coordinator to assist in the administration of home health agency functions, and two staff survey nurses.

The home health agency functions were concerned with certifying home health agencies for Medicare, although no state licensing authority existed for the control of home health agencies. The activities concerned with home health agencies have long been a departmental service, formerly implemented by the Divisions of Nursing and Local Health Srvices.

In early 1977, some 15 HMOs were operating in Illinois, serving some 90,000 residents.

Health Finance

Not long after the department became responsible for licensing general hospitals, the Bureau of Hospitals began to collect data on health care costs. This led to the realization that there was little uniformity in what state agencies were charged when purchasing health care. Charges by each provider covered a wide range for similar services. This fact was brought to the attention of such purchasers of health care as the Departments of Public Aid and Mental Health. It was agreed that the Department of Public Health would determine reasonable costs for a wide variety of health care services and that the purchasing state agencies would follow the department's schedule of fees and charges.

Known as the Hospital Reimbursable Cost Program, this arrange-

ment continued until October 12, 1972, when Governor Ogilvie, by executive order, established the Office of Health Economics in the Department of Finance. The executive order listed the functions of the new agency as follows:

1. To determine rates of payment for state-funded health care programs.
2. To collect data on health care costs, supply and demand for services, and economic trends.
3. To coordinate practices and policies of the various state agencies purchasing health care.
4. To seek innovative ideas in the purchasing of health care.
5. To review existing policies to determine if health care was being purchased in the most economical manner and consistent with objectives regarding quality and state and federal regulations.

This brought to an end the long-time efforts of the department in this area. However, on October 1, 1973, Governor Walker transferred the function back to the Department of Public Health where it was renamed the Office of Health Finance. It was considered sufficiently important to merit high-level status, with its head carrying the working title of an "associate director." Lowell W. Johnson was so appointed by the governor.

The Office of Health Finance was organized into two divisions—the Division of Audit Services and the Division of Research and Development.

The Division of Audit Services was made responsible for auditing of those hospitals participating in seven state-funded health care programs. In 1977, health care purchased from hospitals by these seven programs amounted to more than 50 million dollars. The audits conducted by the Office of Health Finance provided assurance that rates paid to the hospitals were in accord with state and federal regulations and limitations.

The Division of Research and Development was made responsible for rate analysis and the development of health care finance policies for the department. Among the functions of this unit have been the conducting of studies relating to alternatives to the crisis in malpractice insurance, alternatives to national health insurance, and simulated affects of prospective hospital rates on the state budget.

On May 5, 1974, in lieu of expanding its staff of auditors, the Office of Health Finance contracted with Blue Cross/Blue Shield to perform audits of participating hospitals. A "common audit agreement" was signed by the Departments of Public Health and Public

Aid with Chicago Blue Cross whereby the latter would perform special audits of functions involving the seven state sponsored programs simultaneously with the performance of such functions for the Medicare program.

During 1974 and 1975, final audits were performed on transactions that took place in fiscal years 1967 through 1973. These audits resulted in 12 million dollars being returned to the state.

A goal of the Office of Health Finance was the enactment of rate legislation for hospitals, under which hospital charges would be reviewed by an independent board. Such review boards have been established in other states and apparently have been considered successful in reducing the rate of hospital inflation. In three successive years, 1974, 1975, and 1976, this legislation was introduced into the general assembly, but without success. In fiscal 1977, the Office of Health Finance collaborated with the Illinois Hospital Association, interested state departments, and representatives of the health insurance industry, in drafting compromise legislation.

In March of 1977, Lowell W. Johnson resigned and was replaced by Thomas J. Walsh, Ph.D., to head the Office of Health Finance.

Early in Governor Thompson's administration, Health Finance was called upon to serve in a staff capacity to the Governor's Purchased Care Review Board and established rate-setting systems for long-term care, residential treatment for children, and alcoholism programs.

Implied Consent

Legislation enacted in 1967 required the department to develop standards and procedures and to administer a training and licensing program for operators of breath analysis instruments that determine the blood-alcohol content of drivers arrested for being under the influence of alcohol.

This function was assigned to the Division of Disease Control whose chief was Doctor Norman J. Rose. He established the Traffic Safety Section, hiring a small staff headed by Angelo Garella, who, for many years, had operated the department ambulance service of the Maternal and Child Health Program. By 1972, this section had trained and certified 1,390 law enforcement officers in the use of breath analyzers.

The Traffic Safety Section assisted in the drafting of "implied consent" legislation. After many attempts, this type of legislation was enacted into law in the fall session (1971) of the 77th General

Assembly. The law required a driver to take a breath test, administered by law enforcement officers, pursuant to lawful arrest, to determine blood-alcohol content; and provided penalties for refusal to do so. The law became effective July 1, 1972.

With enactment of the law, the Traffic Safety Section was transferred to the Division of Emergency Medical Services and Highway Safety where it was renamed the Implied Consent Section.

Immediately following the enactment of the law, the department, along with the Department of Transportation, made application to the National Highway Traffic Administration for federal funds with which to purchase automated breath analysis equipment. Funds were thus made available to purchase 425 instruments, as well as to retrain all operators that had been licensed previously. By September 1, 1972, all retraining had been completed and the 425 analyzers had been delivered to local law enforcement agencies throughout Illinois.

The Implied Consent Program, mandated under Section 11–501 and 11–501–1 of the Illinois Vehicle Code, is responsible for placing breath analysis instruments in municipal police departments and sheriff's offices and for certification, training, and yearly licensing of operating officers.

In 1974, the department effected a change in the program that resulted in an annual saving of $283,000. The change provided for the calibration of the "Breathalizer" equipment by local police officials instead of limiting adjustment and repair to department inspectors, thus reducing the number of inspectors needed.

In early 1977, there were 364 law enforcement agencies in the program with some 3,000 licensed operators. The program was transferred to the Division of Laboratories in early 1977.

Alcoholism

The Alcoholism and Intoxication Treatment Act of December, 1974, decriminalized public drunkenness and required public inebriates to be taken to a treatment facility. The law also required that the Department of Public Health set up standards for the inspection of alcoholism treatment facilities. A committee was established to advise the director on the development of the standards. Membership on the committee consists of providers of alcohol treatment services and representatives of the Illinois State Medical Society and the Illinois Nurses' Association.

The standards were developed and ready for distribution six

months in advance of July 1, 1976, the effective date of the law. By July 1, 1976, approximately 150 facilities in Illinois were affected by the law and standards.

By the fall of 1976, the department had prepared legislation to give it authority to license alcoholism treatment facilities in order to improve the delivery of treatment services.

On August 23, 1976, Governor Walker signed into law the Alcoholism Treatment Licensing Act. This act gave the department the responsibility for establishing rules and regulations and for administering a licensure program to assure quality service for alcoholics requiring treatment. The program covers all alcoholism treatment facilities not located in a licensed hospital or a licensed nursing home. The Alcoholism Treatment Licensure Program is one part of the Illinois State Plan for Alcoholism Services and is a significant development in providing quality treatment at a reasonable cost in the management of this serious social health problem.

Chapter 9

COMPREHENSIVE HEALTH PLANNING

Planning is relatively new as a visible, formal function in public health. Obviously, no organization can exist without planning; however, what the congress had in mind was not merely planning for health programs or planning for the operations of a single organization.

The original act, passed by the 89th Congress, was entitled the "Comprehensive Health Planning and Public Health Service Amendments of 1966." It became Public Law 89–749 on November 3, 1966.

The purpose of the law, as contained in the act, is as follows: "The Congress declares that fulfillment of our national purpose depends on promoting and assuring the highest level of health attainable for every person, in an environment which contributes positively to healthful individual and family living; that attainment of this goal depends on effective partnership, involving close inter-governmental collaboration, official and voluntary efforts, and participation of individuals and organizations; that federal financial assistance must be directed to support the marshalling of all health resources—national, state and local—to assure comprehensive health services of high quality for every person, but without interference with existing patterns of private professional practice of medicine, dentistry and related healing arts."

This law made mandatory a formal, comprehensive health planning operation on the state level. In a letter to Governor Kerner, the secretary of the U.S. Department of Health, Education, and Welfare, John W. Gardner, requested the designation of a single state agency to assume this responsibility. On December 28, 1966, Governor Kerner so designated the Department of Public Health.

On February 27, 1967, Doctor Yoder established the Division of Health Planning and Resource Development, and appointed Doctor

Edward Press, the medical assistant to the director, as its acting chief. The function was subsequently funded on July 28, 1967.

On September 20, 1967, Doctor Press resigned to become the state health officer of Oregon. Doctor Clifton Reeder, consultant to the department, served as acting chief until March 11, 1968, when Doctor Francis Weber was appointed as chief of the division. Doctor Weber subsequently resigned on June 30, 1970.

The Comprehensive Health Planning Act, also known as the "Partnership for Health," was indeed comprehensive, and introduced a totally new concept to the health field. Its primary intent was to knit together, on a statewide basis, the resources, efforts, attitudes, and cooperation of both the health provider and the consumer into a broad plan for health. According to Doctor William H. Stewart, then surgeon general of the U.S. Public Health Service, "Planning begins, therefore, with the aspirations of society. The first step is to articulate these aspirations into meaningful goals. . . . Once a set of goals has been agreed upon, the second step in the planning process is to break these down into a set of objectives—definable targets toward which we can aim specific efforts. Each objective, insofar as possible, should be measurable so that progress can be intelligently assessed."

What was proclaimed at the federal level as a likely panacea left the health community in a state of shock. Resentment at many levels, and among many professionals, was extensive and the idea was looked upon as an unworkable federal intrusion. There was engendered the fear of having to give up individual and agency prerogatives, to compromise with erratic ideas, and to sacrifice professional know-how for consumer imperception. Among the problems that faced the health community were (1) the difficulty in understanding and differentiating between goals and objectives, (2) the participation of consumers who had had little or no expertise in matters of health, (3) the absence of clear-cut authority to implement planning and dependence upon voluntary participations, and (4) the inadequacy of funding in relation to the intended scope of the program.

Among the requirements of P.L. 89–749, and its amendments contained in P.L. 90–174, was the appointment by the governor of a Statewide Health Planning Council with consumer representation necessarily in excess of 50 percent of the total membership. The demands and requests for appointment to the council were abundant. Most requests came from individuals and agencies with a genuine interest in planning, although too many were obviously motivated by protective instincts.

Finally, with guidance and recommendations from the department, the governor, on May 24, 1968, announced the creation and appointment of a sixty-seven-member Statewide Health Planning Council to advise the department on health needs and to make recommendations therefor.

During fiscal year 1969, the Council met twice—concentrating on its own organization, setting up a steering committee, recommending that planning be on a regional basis, and requesting a list of health providers from the department.

During this time the Division of Health Planning was desperately seeking personnel who might qualify as "planners." No academic curriculum was then in existence, and the Department of Personnel had no title or set of qualifications for such a position. The limited staff, drafted from within the department, was feeling its way, and its efforts might well have been classified as a combination of health education, public relations, and organization. With the limited staff available, numerous meetings were held throughout the state explaining the meaning, objectives, and requirements of comprehensive health planning.

Public Law 89–749 provided for the designation and funding of areawide comprehensive health planning agencies in substate regions. By June, 1969, two such units were organized and funded: Comprehensive Health Planning for Metropolitan Chicago and the Bi-State Metropolitan Health–Hospital Planning Agency, which included the Illinois counties of Madison, St. Clair, and Monroe, plus four Missouri counties. In addition, organizational efforts had begun in Will, Grundy, Kankakee, Kane, and Lake Counties and in Rockford, Peoria, Springfield, and Carbondale.

In August, 1969, Governor Ogilvie created the position of Coordinator of Health Services; and, in October, he appointed Albert W. Snoke, M.D. to that position. Doctor Snoke, a former professor of epidemiology and public health at Yale University, came to Illinois from his most recent position as director of the Yale–New Haven Hospital. The staff of the department's Division of Health Planning was directed by Doctor Yoder to assist the coordinator in every practicable way.

During fiscal year 1970, a task force developed a plan for the geographic regionalization of Illinois for state administration and planning purposes. Also, a contract was negotiated with the Health Careers Council of Illinois to conduct a health manpower survey of the state.

Because of the large number of state agencies, besides the department, with varying degrees of health responsibilities, the

governor created a Health Services Cabinet in April, 1970. The members included the directors of the Departments of Public Health, Mental Health, Children and Family Services, Public Aid, Local Government Affairs, Registration and Education; the Division of Vocational Rehabilitation; the Governor's Office of Human Resources; the Illinois Institute for Social Policy; the Bureau of the Budget; and the Board of Higher Education. The governor served as chairman; the coordinator of health services, Doctor Snoke, as secretary. The function of the so-called health cabinet was to determine state health needs and to coordinate interdepartmental activities assocated with health.

Earlier, between 1966 and 1970, Doctor Yoder had established a similar arrangement, although on a more limited scale, by creating an interdepartmental council of directors of the Departments of Public Health, Mental Health, Public Aid, and Children and Family Services and the Division of Vocational Rehabilitation.

On November 16, 1970, the governor issued Executive Order #6, transferring the statewide responsibility for comprehensive health planning from the Department of Public Health to the Office of the Governor. On February 1, 1971, the governor established administrative rules and regulations for the authority, organization, and management of what became known as the Comprehensive State Health Planning Agency (in the Governor's Office). The coordinator of health services was appointed executive director of the agency.

It should be noted that the governor's Executive Order #6 in 1970 and Doctor Weber's resignation resulted in the abolishment of a major health planning unit in the department when Doctor Yoder completed a reorganization that same year.

The Comprehensive State Health Planning Advisory Council was reorganized and reconstituted, ostensibly to provide more equitable representation on a geographic basis. The coordinator's wife, also a physician, with the added qualification of a master's degree in public health, was placed on the department payroll. Although her main duties were performed in the Comprehensive State Health Planning Agency, she brought to the staff of that agency expert public health know-how.

Governor Ogilvie, in April, 1971, delivered a special message on health, wherein he advocated—

1. The encouragement of new, improved systems for the delivery of health care and services, such as health maintenance organizations.
2. The strengthening of state and regional comprehensive health planning.

3. Legislation for certificates of need and for low interest loans for the construction and expansion of health-care facilities.
4. The control of increasing costs of health care.
5. The increase in availability of health manpower.
6. The improvement of the care of individuals in long-term-care facilities.
7. The improvement in the quality of blood used in transfusions.
8. The development of a statewide system of facilities for the critically injured.
9. The development of sound organization and staffing for health activities in the state.

Public Act 77–643, enacted on July 26, 1971, established the Comprehensive State Health Planning Agency (CSHPA) as a statutory agency of Illinois government with an appropriation of $300,000 for operations to be matched by federal funds, plus $250,000 for development of regional and local comprehensive health planning for the year ending June 30, 1972.

The nine major points in the governor's health message were all significant, if not as extensive or detailed as hoped for by most health professionals. Undoubtedly the transfer of the health planning function to the Governor's Office enhanced its authority and stature, while making it less responsive to the major health organization in the state. The appropriation to the newly created Comprehensive State Health Planning Agency was substantial compared with the planning funds previously available to the department. The appointment of a health services coordinator and a health cabinet was innovative.

Some of the governor's recommendations subsequently became realities. A health maintenance organization law was passed; a blood labeling act came into being; an emergency medical services system was established; and the "Illinois Health Facilities Planning Act" (P.A.78–1156), requiring a permit to construct, modify, or establish a health-care facility was passed.

These proved to be substantial accomplishments but cannot be credited in the main to the Comprehensive State Health Planning Agency. That agency's existence made automatic its participation in all health thrusts to varying degrees. The CSHPA, during Governor Ogilvie's administration, appears to have made pedestrian progress in developing a strong coordinating role. Activities, studies, and surveys were pursued in abundance, all of which were considered essential in "getting the show on the road." However, all of this effort, primarily organizational in character, showed limited progress toward coming together in a grand plan. A tremendous task had

been assigned to the coordinator with a relatively brief period, as it turned out, to bring about substantial results.

In December, 1972, the coordinator of health services submitted a report to the governor entitled "Health and Social Services in the State of Illinois." This report dealt, at some length, with the numerous and complex problems of health in Illinois and offered recommendations for change and solution. It was a scholarly compilation and merits study by those interested in improving the health services of the state.

In the fall of 1972, Governor Ogilvie was defeated for reelection by Dan Walker. The coordinator of health services, with the departure of Governor Ogilvie, resigned his position. The new governor appointed Doctor Mark Lepper to that position. Doctor Lepper came to the job with experience in public health, having been a professor of preventive medicine at the University of Illinois. Immediately prior to his appointment, Doctor Lepper had been executive vice president for academic affairs and dean of the medical college at Rush–Presbyterian St. Luke's Medical Center in Chicago.

A successful working relationship between the Comprehensive State Health Planning Agency and the department was assured by the fact that Doctor Lashof, director of the Department of Public Health, had worked with Doctor Lepper in the Chicago institution.

In the course of this close working relationship, and by virtue of the geographic proximity of the two agencies, the department absorbed the responsibility for handling and processing all financial matters relating to the CSHPA, although the latter retained authority over its appropriation and expenditures. This arrangement, although unusual, did prove to be money-saving and efficient.

Planning depends essentially upon the voluntary cooperation of individuals, agencies, societies, and facilities. However, there are areas in which nothing less than federal and/or state laws can bring about desired results. In response to the growing concern over the rising costs of medical care and unnecessary health facility construction and capital expenditure, the Department of Public Health, with support from the Illinois Hospital Association and the local (B agency) health planning groups, succeeded in obtaining passage of the Illinois Health Facilities Planning Act (P.A. 78–1156) in 1974.

Discussion of this act falls logically into this section on "Planning" and into another section of this volume entitled "Institutional Programs." Administratively, also, it has a foot in each of two units of the department.

The act provides for a thirteen-member, consumer dominated, decision-making board that is responsible for issuing permits for

construction of new health facilities and capital expenditures over $100,000. The department is responsible for providing all the staff work for the board. This includes the development of a state health facilities' plan, and rules and criteria for project review. Subsequently, the Department of Public Health developed, and the board adopted, an acute-hospital facility plan, a long-term-care chronic disease and rehabilitation-facility plan, criteria for modernization projects, criteria for new and technologically innovative equipment, and criteria for financial and economic feasibility. A facility must prove to the board that it is in conformance with all applicable rules in order to obtain a permit for facility expansion, modernization or new construction. The purpose of this program is to further assist the citizens of Illinois in obtaining quality care at reasonable cost.

In September of 1975, the governor approved an act (P.A. 79–939) to amend the Illinois Health Facilities Planning Act. This placed the responsibility for its administration—not just staff work—in the department. This responsibility was assigned to the Office of Health Facilities and Quality of Care, within which was established a Division of Planning and Conformance to administer the act. George Lindsley, M.P.H., who at one time headed the Bureau of Hospitals in the department and who had been the administrator for the Comprehensive State Health Planning Agency, was appointed chief of the Division of Planning and Conformance as well as executive secretary of the Health Facilities Planning Board.

The same amendatory act, approved in September, 1975, also brought changes in the state's "Comprehensive Health Planning Act." The functions and responsibilities of the Comprehensive Health Planning Agency were transferred to the department—back where it all began under Doctor Yoder in 1967. Numerous other changes were effected by P.A. 79–939.

An Office of Planning Coordination was established and shown organizationally as reporting only to the director of the Department of Public Health. This office, placed under the guidance of the executive secretary of the Statewide Health Coordinating Council (SHCC), was assigned the responsibility of providing staff support and other services for the SHCC as required, and to conduct the state comprehensive health planning activities for which the department was again responsible. These included the development of a state health plan made up of the plans of all the health systems agencies in the state with incorporation of the plans of health related state agencies for approval by the State Health Coordinating Council; participation in review of applications for federal funds for certain state programs; provision of assistance to the SHCC in reviewing the

state medical facilities plan; participation in the review of services offered in health institutions; and review of the performance and budgets of health systems agencies.

The establishment of a Statewide Health Coordinating Council, referred to above, was a significant provision in P.A., 79–939. In effect, the SHCC was a newer version of the old Comprehensive Health Planning Advisory Council. Requirements and limitations too numerous to record were necessarily incorporated in the state law in order to be in conformance with federal law.

Established in late 1976, the first SHCC consisted of fifty-six members appointed by the governor. Thirty-three of the appointed members represented the eleven health systems agencies in Illinois. Each agency was entitled to three members, two of whom were consumers of health care who were also not providers of care.

The State Center for Health Statistics was established in 1974 as an outgrowth of the Total Health Information System (THIS), established by Doctor Yoder, and of his assignment of departmental statisticians to the Division of Planning and Research Development. The State Center, placed in the Office of Planning in October, 1976, is responsible for unifying and improving the collection, analysis, reporting, and publication of statistical and other information related to health and health care. The Center is also responsible for coordinating efforts with the Cooperative System of the National Center for Health Statistics. With the governor's designation of the department as the State Comprehensive Health Planning Agency under P.L. 93–641, the Center simultaneously became the state agency's representative in its dealings with the eleven Illinois local health systems agencies in matters of health data.

On April 17, 1976, Doctor Lepper resigned his position as coordinator of health services. The successor to this position was called the executive secretary to the Statewide Health Coordinating Council. The appointment required senate confirmation (P.A. 79–939). This position had remained vacant since its creation in 1975. In the summer of 1977, Doctor Peterson announced the appointment of Roy W. Armstrong, Jr. Immediately prior to his appointment, Mr. Armstrong had been chief of the Health Planning Branch in the Region 5 office (Chicago) of the Department of Health, Education, and Welfare. His appointment terminates on January 15, 1979, at which time he becomes eligible for re-appointment. He joined the department on an intergovernmental personnel loan arrangement.

Chapter 10

ADMINISTRATIVE SERVICES

As generally defined by the department, administrative services (also called management services in recent years) are those functions that are either managerial in character or provide a supportive and coordinating service to the program units. These so-called administrative services have borne various titles throughout the administrations of various directors. Among the services usually considered administrative or supportive have been health education; budget and fiscal operations; data processing; personnel management; laboratories (in recent years); local health administration or services; nursing (from time to time); training; legal and legislative services; statistics and a miscellany of services such as inventory and records control, communication, messenger and mail services, leasing, automotive supervision, etc. Almost invariably, the individual with overall responsibility for these functions has been the director's closest assistant and counselor.

Health Education and Information

During the 1960s, the Bureau of Health Education emphasized a stated mission whereby individuals, both individually and collectively, were to be motivated to take action for maintaining or improving their health through adopting positive health behaviors. High priority was also accorded to improving the public's health through facilitation of in-service training opportunities for public health professionals, including public educators employed by state, local, and voluntary health agencies.

Social health problems were also accorded priority, including drug abuse, smoking, alcoholism, and poverty. Basic health education services were emphasized through the distribution of films and pamphlets in large quantities, while exhibits were constructed for

use by the Illinois Department of Public Health, as well as by other health agencies. The staff complement of the bureau had reached thirty-eight by 1969.

In December of 1969, the Bureau of Health Education, along with the rest of the Department of Public Health, was relocated from its quarters in the State Office Building into an office within the Jefferson West Building Complex at 525 and 535 West Jefferson Street. This was the first of several moves to occur during the early 1970s.

The Bureau of Health Education, in August, 1970, as part of a departmentwide reorganization, became the Division of Education and Information within the Bureau of General Administration. In December, 1973, the Department of Public Health was again reorganized with the Division of Education and Information becoming a part of the Office of Management Services.

During the early 1970s, emphasis was placed on the Public Information Unit within the division. This unit, which heretofore had been relegated to a minor position within the division, was allowed to expand its efforts to communicate with the public by utilizing the medium of television. Public service announcements on such diverse topics as immunization, milk sanitation, emergency medical services, voluntary blood donations, drug abuse, and recreational facilities' sanitation were created by the public information unit and telecast throughout Illinois. Several of these public service announcements subsequently won international awards. Use of the news conference and radio actuality also increased the department's ability to communicate information concerning health issues, trends, and hazards to the public.

In July, 1972, due to fiscal constraints, the operation of the film library was discontinued, and all films were transferred to the Illinois State Library or to the agencies that had purchased some of them. Shortly thereafter, the centralized distribution of health materials was discontinued as a function of the division. By July of 1975, the reference library service was also discontinued, with most publications being transferred to the medical library of the School of Medicine, Southern Illinois University.

Along with the discontinuation of services, the staff size of the division was reduced in fiscal year 1972 to fourteen: eight public health educators, two public information officers, three secretaries, and one photographer. (The last position was discontinued in 1977.)

Emphasis of the division, at this time, was placed on provision of educational and informational support services within the department at both the central office and regional office levels. Efforts to assist in identification of the educational/informational components within

local health department programs also continued, although it also became necessary to temporarily suspend assignment of public health educators to regional offices.

With the 1973 reorganization of the department, additional responsibilities were assigned to the Division of Education and Information, including the administration of the vital records program, health data analysis, graphic arts services, and coordination of the department's training efforts. The division chief was appointed Deputy State Registrar and served in this capacity from February 1, 1974, to May 1, 1976.

On May 1, 1976, the vital records program was removed from the Division of Education and Information and established as a separate division. The removal of the data analysis function took place with the creation of the State Center for Health Statistics.

During 1975, public health education services were restored in four regions by the assignment of two public health educators. In addition to the continued emphasis on provision of quality educational/informational support services, staff of the division remained active in professional societies at both the state and national levels, including the Society for Public Health Education; the Illinois Chapter, Society for Public Health Educators; the Illinois Public Information Officers' Roundtable; the Conference of State and Territorial Directors of Public Health Education; and the Illinois Public Health Association.

In 1977, the mission of the division remained that of providing a broad range of services to assure the planning and implementation of educational and informational components within the health programs and services conducted by the Illinois Department of Public Health. The staff of seventeen included eleven public health educators, one public information officer, one graphic arts illustrator, and four clerical personnel, one of whom was assigned to the graphic arts unit.

Lynford L. Keyes, M.P.H., served as chief of this unit from July 16, 1961, to June 30, 1971; and Stanley R. Miles, M.P.H., became the division chief on August 1, 1971.

The numerous activities of this unit have not been specifically documented. To do so would be to describe the health education aspects of every departmental program, the consultation services provided to all local health agencies in the state, and the public relations activities that have given the department visibility and public understanding of its efforts to improve the health of the citizens of Illinois.

The function of the health educator has never been generally

understood or accepted—even, in some cases, by public health professionals. In local health departments, for example, a qualified health educator was almost always the last to be added to the staff and then, for want of comprehension, usually assigned to the preparation of the agency's annual report as an initial test. Within the department, program directors in many instances have failed to realize that a program without a health education component lacked the yeast of success. In the period covered by this volume, there have been numerous "freezes," cutbacks, reductions in appropriations, or similar constraints upon the operation of the department. Almost invariably, health education and training have been among the first to be singled out for economies. At one time, a relatively new and imperceptive Bureau of the Budget would have eliminated the health education function but for the determination of the director of the Department of Public Health.

Laboratory Highlights

The laboratory of the department was established in 1904, and has been well known throughout its existence for its excellence of performance, research, and contributions to innovative testing. It has had the leadership of learned scientists and an extraordinarily well qualified staff, especially after September 1, 1930, when Howard J. Shaughnessy, Ph.D., became its chief.

When Doctor Yoder came to the directorship, Doctor Shaughnessy was still in charge of the laboratory operation and the Division of Laboratories was made up of the Bureaus of Biologic Products, Diagnostic Services, Laboratory Evaluation, Toxicology, and Virus Diseases and Research.

The laboratory unit exists primarily to render necessary services in the implementation of departmental programs, although not limited to that function. Services and programs emanating from the department laboratories have also been of direct benefit to physicians, dentists, hospitals, other laboratories, coroners, law enforcement agencies, local health departments, veterinarians, and other state agencies.

The laboratories of the department have a record of developing new and revolutionary techniques. In fiscal year 1961, the fluorescent antibody test was introduced. This permitted the direct microscopic immunological identification of specific organisms such as β-hemolytic streptococcus, pathogenic strains of E. coli, and those for rabies.

In fiscal year 1962, a new diagnostic serological test for fungal

disease was developed. Since histoplasmosis is endemic in Illinois, this diagnostic service was greeted enthusiastically, especially by physicians.

In fiscal year 1964, the Guthrie phenylalanine screening test for phenylketonuria in newborn infants was introduced in the laboratory. Hospitals were then invited to submit blood specimens from the newborn on a voluntary basis pending hoped-for passage of mandatory legislation. Also that year, a new early screening serological test (hemagglutination inhibition) for mosquito-borne encephalitis viruses (arboviruses) was introduced.

In fiscal year 1965, a new diagnostic service for German measles (Rubella) was evaluated and utilized.

In fiscal year 1966, a new specific confirmatory test for syphilis (Fluorescent Treponemal Antibody–Absorbed) was evaluated and introduced, permitting the discontinuance of two other tests for the disease.

The burden of the high volume of simple routine tests had long impeded the laboratory from expanding its reference and consultive services. A major step toward this end became possible in fiscal year 1967 when the laboratory of the Chicago Board of Health moved into a new and modern facility and assumed responsibility for the large volume of routine syphilis serology for Chicago physicians. This resulted in the testing of more than 90,000 specimens annually for the department laboratory.

In fiscal year 1970, a new screening test for syphilis (RPR card) was introduced after a careful evaluation. It replaced the VDRL, proving to be as sensitive and more specific. The diagnosis of syphilis had reached a new high in precision with this new test when combined with the confirmatory (FTA–ABS) treponemal test.

In fiscal year 1972, a federally funded statewide surveillance program to detect gonorrhea in the asymptomatic female was organized and implemented. New transport media allowed, for the first time, the shipment of the very labile specimens to the laboratory.

Although the Division of Laboratories has always been considered primarily a service function, it has been delegated responsibilities from time to time of a programmatic nature.

Concurrent with the creation of a commission to survey and study clinical laboratories, blood banks, and blood bank depositories in fiscal year 1963 (S.B.1104), legislation was enacted (S.B.1103) that required the registration of clinical laboratories, blood banks, and blood bank depositories. This law authorized the department to inspect all such facilities, provided penalties for violations, and

appropriated $30,000 therefor. This responsibility was assigned to the Division of Laboratories for implementation. This legislation was known as the "Illinois Clinical Laboratory Registration Act."

The following year, fiscal 1964, there was enacted the "Illinois Clinical Laboratory Act" (H.B.1143), which provided for the licensing of independent clinical laboratories (nonhospital) and which carried an appropriation of $100,000. The Registration Act was repealed. Similarly H.B.1142, known as the "Illinois Blood Bank Act," was enacted into law with an appropriation of $100,000. Responsibility for both these laws was assigned to the Bureau of Laboratory Evaluation of the Division of Laboratories.

The Illinois Department of Public Health was one of the first state health departments in the country to produce biologics. The production of typhoid vaccine, diphtheria toxoid, rabies vaccine, and silver nitrate solution for ophthalmia neonatorum was begun in July 1, 1933, at the Springfield state fairground laboratory. In 1942, the biologics laboratory was moved to the main laboratory in Chicago, and continued to function until 1969. This unit also began, on July 1, 1933, the practice of testing for the potency and safety of all biologics purchased by the department and which were distributed free to physicians and hospitals. Subsequent to the discontinuance of production, an outbreak of diphtheria in Chicago, in January, 1970, required the biologics laboratory to initiate, temporarily, a crash program to produce diphtheria toxoid to meet an unprecedented demand for mass immunization. As a matter of interest, the production of biologics by the department was vigorously opposed from time to time by Representative Paul Powell on the principle that the state was in competition with private enterprise. Of similar interest is the opposition the department encountered at frequent intervals from the new Bureau of the Budget for distributing drugs and biologics free to physicians and hospitals, the cost of which usually ran into many hundreds of thousand dollars biennially. However, the practice proved to be highly successful in improving and maintaining the immunization status of Illinois children and continues in 1977.

The history of the department laboratories reflects some major setbacks due primarily to financial limitations. Early in the Ogilvie administration, the governor had a bill introduced creating the Bureau of the Budget. This bill was passed by the general assembly and approved by the governor, thereby creating a new and powerful agency under the governor. This brought to state government a new concept in budget preparation and the determination of needs, in the case of the department, by other than professional health workers.

The department soon came to grips with the new budget makers—and lost. The Bureau of the Budget, in its first consideration of department finances, gave the director a total allowable appropriation figure that was considered by the director and his staff as unreasonably inadequate. After much deliberation, and numerous conferences with his staff, the director submitted his budget as originally prepared—some $10 million in excess of the Bureau of the Budget figure. This move was heartily applauded by all the department's bureau and division chiefs. However, the Bureau of the Budget then imposed a zero-based budget upon the department. This resulted in the loss of needed funds and, of course, a great number of allowable mandays.

As a result, the Division of Laboratories began the new fiscal year 1970–1971 with the loss of forty-four positions, necessitating the strict curtailment of services. Services terminated were syphillis serology, test for phenylketonuria, and agglutinations. These were chosen because they could be purchased through private laboratories.

Another setback resulted when fifty-seven positions in the Division of Laboratories, engaged in sanitary bacteriology, were transferred by mandate to the newly created Environmental Protection Agency. These fifty-seven positions constituted the entire staff of the sanitary laboratory section, although 40 percent of the sanitary laboratory effort was still required to support the sanitation programs remaining in the department.

The Environmental Protection Agency shared the department's laboratory in the State Capitol Building until December, 1970, when both agencies were evicted without warning. Laboratory facilities are of a special nature and cannot be found ready and waiting for tenancy; however, quarters were found at Ninth and Jefferson Streets in Springfield. The building became a laboratory after a long period of construction by the landlord (made possible through increased rentals until the modification costs were amortized). While construction was in progress, services performed were necessarily at a substantially reduced level.

During fiscal year 1972, the division continued reorganization and exhaustive analysis and planning to streamline statewide laboratory services. An experienced manager, James Thayer, was appointed as executive assistant to the division chief. In the fall and winter of 1971, the Rock Island, Champaign, and East Saint Louis laboratories were closed, and all services consolidated in the remaining laboratories in Carbondale, Chicago, and Springfield. The removal of the Environmental Protection Agency's laboratory staff from the Spring-

field facility permitted the renovation of the building and re-establishment of the division's central environmental reference laboratory. Also, an environmental toxicology unit was established to centralize all heavy metal analysis. A combined Environmental Protection Agency/Public Health pesticide unit was established in order to share expensive instrumentation and expert staff. The Environmental Protection Agency continued the southern Illinois laboratory operations in the department's Carbondale facility.

In June, 1973, the main laboratory in Chicago moved from its antiquated housing into a new and modern facility at 2121 West Taylor Street, some nine years after the structure had been authorized by legislation in 1963. The Food and Drug laboratory (formerly belonging to the Illinois Department of Agriculture and located on Franklin Street in Chicago) was also moved into the new building and was consolidated with the environmental laboratory.

During fiscal year 1973, the virus unit introduced the test for "Australian Antigen" for hepatitis B. Also initiated that year by the laboratory evaluation unit were blood tests for sickle cell disease and other hemoglobinopathies. This service was offered to clinics involved in genetic counseling for indigent populations.

That year, the Division of Laboratories uncovered a new serotype isolated from an African clawed frog at the Brookfield Zoo, Brookfield, Illinois. The organism became known as "Salmonella enteritidis/Brookfield."

On September 6, 1973, Governor Walker signed into law the Lead Poisoning Prevention Act (H.B.794), which restricted and limited the sale and use of substances containing lead; encouraged and supported the development of early detection and treatment programs; and required the reporting of cases with high blood-lead levels. This resulted in the rapid expansion of blood-lead analyses by the laboratory.

Following the employment of a manager (referred to previously), an administrative section was established in fiscal year 1973 to upgrade the management and services operations of the division. Growing demands for management studies, budget and fiscal accountability, and cost analyses occupied the limited resources of this section. The division, in 1973, participated in a study conducted by the U.S. Center for Disease Control to establish a system of relative weight factors for all tests to provide more accurate reflection of work measurement.

The next year, in fiscal 1974, a laboratory training unit was formally established and a training coordinator appointed. Work-

shops and problem-solving clinics were held, with emphasis directed toward the small hospital laboratory.

Automation of laboratory testing was fast becoming a popular conception, primarily in those areas where the number of analyses and concomitant costs were sufficient to justify the purchase of sophisticated, expensive equipment, and where these analyses were being developed at an accelerating rate. The laboratory leadership, recognizing this trend at an early date, was able to move substantially in this direction in fiscal 1974. It acquired a computerized gamma spectrometer in the radio chemistry unit; a gas chromatograph mass spectrometer–computer system in the toxicology unit; and a gas chromatograph for the identification of anaerobic bacteria. All of these contributed significantly to reduction in the time needed for sophisticated analyses.

In 1975, the division efforts to identify and recommend the most beneficial use of the unfinished half of the Taylor Street laboratory building culminated in approval and the initiation of planning for occupancy of the space by the University of Illinois School of Public Health. The proposed proximate relationship between the laboratory and the school was expected to result in significant contributions to public health in Illinois.

The Environmental Protection Agency laboratory staff, sharing space in the Carbondale laboratory, moved to the Marion regional office building. This 1975 move permitted renovation of the Carbondale facility and re-establishment of physical facility standards to meet U.S. Public Health Service/Food and Drug Administration requirements for milk and water laboratories.

Events of the year demonstrated the need for the public health laboratory to continually develop new procedures and expertise to insure its ability to respond to the unusual or newly recognized problems affecting the public health.

In fiscal year 1976, the implied consent and substance impairment programs were transferred to the Division of Laboratories following a sharp reduction in the regular program field staff. The certification and maintenance of breath-alcohol testing instruments, and the training and certification of police operators, were integrated with a new plan to use simulated standard reference alcohol solutions to standardize and validate instrument performance.

The Carbondale laboratory absorbed most of the tuberculosis testing in the southern part of the state following the closing of the Mount Vernon State Tuberculosis Sanitarium.

Pesticide analysis of fish from Illinois waters was undertaken in

cooperation with the Division of Food and drugs and the Department of Conservation.

Also, in fiscal year 1976, the Chicago diagnostic laboratories cooperated with the University of Illinois School of Public Health in a study of the dissemination of infectious agents into the atmosphere during the aeration phase of sewage plant operation. The study was funded by a federal Environmental Protection Agency grant to the University of Illinois and the laboratory support was contracted to the department.

On July 1, 1977, Richard A. Morrissey, M.P.H., retired as chief of the Division of Laboratories, completing forty years of service to the laboratory. He had succeeded George Forster, Ph.D., who had retired in 1967. In October, 1977, Doctor Peterson appointed M. Samuel Sudman, Ph.D., as chief of the division. Doctor Sudman, prior to his recruitment, held a comparable position in the Tennessee Department of Public Health.

Also in 1977, the closing of the Carbondale laboratory was proposed, for reasons of economy. Although state spending and state employees are generally resented by the public, a different attitude prevails when a reduction in those areas affects a specific community. The proposed closing, justified or not, was strenuously opposed by community leaders and local members of the legislature.

Electronic Data Processing

When Doctor Yoder became the director, the major functions of the Division of Statistics were the processing and maintenance of vital records (births, stillbirths, deaths, legitimations, and delayed birth registrations) and the collection and analysis of health statistics. He recognized that this unit was poorly housed and understaffed and that, even with the expenditure of long hours of work by a well qualified staff, it was impossible to keep up with the workload. The need for current health data was becoming increasingly important to the intelligent operation and direction of departmental programs and policies.

The use of tabulating and statistical equipment was obviously slow and cumbersome; and improved equipment, e.g., the computer, was making itself felt in business and industry. Doctor Yoder directed his chief of the Bureau of Statistics, and the head of the statistical section, to obtain examinations from a consulting firm, and to subject members of the statistical staff to a test that would indicate their aptitudes for some aspect of computer science. After determining their potential skills, a period of training began, offered

free in some cases, and requiring a fee in others. Training time was largely the employee's own, although time off was allowed if and when necessary. All qualifying staff so engaged showed marked enthusiasm and good progress. Within a comparatively short time, a computer cadre was ready. In the meantime, a computer had been placed on order and was delivered in the fall of 1962, whereupon all existing applications were converted from tabulating equipment to an IBM 1401 computer.

It should be noted that the department was one of the first agencies in Illinois state government to utilize a computer and among the very first state health departments in the nation to do so.

Within a year of the computer installation, the data processing time required for vital records dropped from 90 percent to 55 percent of the total available, with the Divisions of Sanitary Engineering, Administration, Laboratories, and Hospitals and Chronic Illness all seeking service. By the end of fiscal year 1964, vital records was occupying 43 percent of the computer's time, with the other major users being communicable disease control, dental health, sanitary engineering, tuberculosis control, and maternal and child health.

It is interesting to note that many of the program directors, having little or no conception of the advantages to be gained or how to convert their operations to computer use, were initially reluctant to consider making a change.

On August 1, 1967, the Bureau of Electronic Data Processing was established as one of six bureaus in the Division of General Administration, with Isabelle Crawford, M.A., as its chief. Utilizing an IBM 360/30 by then, over 100 separate files were being maintained on the computer, and over 500 programs had been written for the processing, storing, and retrieval of data.

This progress engendered the idea of a single computer-based health information system to permit the integration of demographics, public and private health resources, status, and need data. It was envisioned that such a system would enhance speed and accuracy in accessing large volumes of significant data and provide program administrators with great capability for planning, decision-making, investigative efforts, and regulative functions.

In June of 1968, the first steps were taken to establish a Total Health Information System (T.H.I.S.) with the bureau staff working in conjunction with the IBM Corporation under contractual agreement. The requirements study was completed in October, 1968; the design concept was completed in March, 1969; and the detail design of the major subsystems completed in early 1971.

In fiscal year 1969, a departmentwide daily activities reporting

system (DARS) was developed and implemented. This was created to justify the allocation and expenditure of funds; to establish a valid base for matching (federal) funds; to lay the groundwork for future performance budgeting; and to provide program directors with an additional tool for program management and evaluation.

In April, 1971, the first program area to be incorporated into the Total Health Information System was long-term care. By this time designs had also been completed for the programs in hospital licensure, venereal disease, radiological health, food and drugs, clinical laboratories, and the tuberculosis registry.

In April, 1969, the department had begun to convert its entire computer operation from the 360/30 configuration to the 360/50 operated by the Management Information Division of the Department of Finance, which began the centralization, insofar as possible, of state-operated computers. The conversion was completed in September, 1969, consuming some 2,200 manhours of staff time.

The chief of the Division of Electronic Data Processing transferred to the Management Information Division on February 1, 1971; and Thomas E. Stuckey, B.A., was appointed as chief.

By the end of the Yoder administration, the more than twenty data systems were supported by the unit, which had become the Division of Electronic Data Processing in the Bureau of General Administration.

During the Lashof administration, the Division of Electronic Data Processing was partially reorganized, those changes remaining in effect in 1977. Two major sections exist: (1) the Computer Science Section, which is responsible for the design, implementation, and maintenance of all computer systems within the department; and (2) the Operations Section, which is responsible for providing the user with reports on a scheduled or special request basis. The latter is achieved by utilizing the services of its data preparation unit, the data input unit, and the production control unit.

Following February, 1973, sixteen additional data systems were supported by the division, the majority of which were for the Office of Environmental Health (formerly the Office of Consumer Health Protection and the Bureau of Environmental Health). A computer-based general ledger accounting system was also being developed toward the end of the Lashof administration.

By early 1977, over fifty data systems were being supported.

Accounting and Auditing

These two functions are considered together because they both

relate primarily to department finances and programs, although they are distinct from each other in their functioning.

In 1961, the accounting function was performed by the Bureau of Accounting and Finance in the Division of General Administration. The bureau, at that time, was responsible for maintaining financial records in accordance with statutes and regulations established by the state and by federal agencies making grants-in-aid to the department, for exercising control of inventory as property manager of the department, for receiving and accounting for all fees and receipts, for preparing financial reports, and for assisting the divisions and bureaus in the financial and business aspects of purchasing.

The chief of the unit was Robert T. Malone, who had been in that position for many years, and was the first person to serve in that capacity. His death in 1968 resulted in the appointment as acting chief of Ira Shipley, a department accountant for many years. Walter E. DeWeese, a well-qualified accountant, who had been brought in to provide additional depth to the accounting staff, was later appointed as chief of the division.

By early 1970, Mr. DeWeese had implemented an automated accounting system and had improved the system for reporting the department's financial status to the director, his assistants, and bureau and division chiefs. The Bureau of Accounting and Finance developed a closer working relationship with the various units and programs—the users of funds.

With the reorganization of the department in 1970, the bureau was renamed the Division of Accounting and Finance. The establishment of the Bureau of the Budget brought the division to center stage. A budget review and analysis section was established with responsibility for preparing program budget analyses, consulting with all units concerning budgets, determining cost benefits of new and existing programs and services, and consolidating all requests into a departmental budget.

In 1971, the Division of Accounting and Finance became the Division of Budget and Fiscal Operations, thereby giving visibility to its budgetary responsibilities.

Mr. DeWeese served as chief of this unit until June 1, 1975, when he was appointed chief of the Division of Internal Audit. He was succeeded by George Akehurst who had been head of the budget review section.

During the latter Lashof years, the department set out to develop a computer-based general ledger accounting system to enhance (1) control of appropriations, (2) accounting control of assets, (3) genera-

tion of consistent, reliable cost data, and (4) collection of all federal funds available. Design of the first five subsystems was completed late in 1976. Operation of the entire system is scheduled for July, 1978.

For many years prior to 1967, the Legislative Audit Commission had urged the department to establish an internal auditing program. The department procrastinated due to lack of funds and an apparent indifference on the part of the administration. However, the commission's urging became so insistent that an internal auditor, Charles Meader, was employed in March, 1967. At that time there were no statutory or state guidelines so the internal auditor depended on the auditor general for the legislative audit commission for advice.

Then the 75th General Assembly passed the Internal Auditing Act (S.B.1221), and the governor approved. This act established the qualifications for an internal auditor and specific guidelines for the service.

Mr. Meader's services were abruptly terminated by his death. He was replaced in July, 1969, by Jesse Pride. Accomplishments were necessarily limited while a staff of auditors was being recruited and trained.

The internal audit section, in the Office of the Assistant to the Director, was dissolved in July, 1973, early in the Lashof administration. It was replaced in September, 1973, by a unit called the management audit section and was headed by Al Marshall, a former legislative aide. There existed a possibility that this unit, in terms of responsibilities and qualifications, did not meet statutory requirements. The fact of noncompliance was brought to the director's attention, whereupon she issued Directive #5–75 on June 30, 1975, that established a Division of Audits in the Office of Management Services and outlined the responsibilities of that division in conformance with the pertinent statute. Walter DeWeese replaced Al Marshall. The division was staffed by two accountants and a secretary from the Division of Budget and Fiscal Operations and an administrator from the Division of Emergency Medical Services. The internal auditing program, after years of a see-saw existence, has been recognized as a legitimate, necessary, and desirable function for the improvement of all departmental operations.

Statistics and Vital Records

These two functions are being considered together because, for many years, they were together administratively and organizationally

and because the vital records function has always been an important source of biostatistics.

In 1961, Eugene L. Wittenborn was named acting chief of the Bureau of Statistics. This responsibility was delegated by the Cross administration after Doctor O. K. Sagen, an expert statistician and demographer, left for a position with the federal government in Washington, D.C. This arrangement was necessarily effected because extensive recruitment efforts and in-house observations failed to find an individual with both administrative and statistical abilities. Mr. Wittenborn, while competent in the area of administration, lacked statistical and vital records know-how. Within the bureau, however, there were persons well-qualified to head up the statistical, tabulating, and vital records functions. By virtue of a close working relationship, the bureau operated effectively in terms of the accomplishments expected in those days.

Historically, the registration of births and deaths with the Department of Public Health dates back to 1916. Prior to that time, births and deaths were registered with county clerks. With the passage of time, additional registrations were made the responsibility of the department. These included fetal deaths, delayed birth registrations, marriages, divorces, annulments, legitimations, and adoptions.

The 74th General Assembly, with the governor's approval, amended the Vital Statistics Act (S.B.806) by increasing the search fee for births and deaths from $1.00 to $2.00. It should be noted that a fee has never been charged for any type of certificate—only for the search therefor. This requirement has frequently led to public dissatisfaction when the search results in negative findings. The 75th General Assembly enacted similar legislation in 1967, raising the fee for certificates of marriages, divorces, and annulments to $2.00.

In fiscal year 1968, all data processing was removed from the Bureau of Statistics and was made a bureau in its own right—the Bureau of Electronic Data Processing. Remaining in the Bureau of Statistics were the statistical functions and the Office of Vital Records.

On January 1, 1968, all new vital records forms were placed in use. Revised handbooks for hospitals and funeral directors, interpreting the use of the new forms, were distributed previously. A physician's handbook was written, edited by the Illinois State Medical Society, and distributed in the fall of 1968.

On March 1, 1969, the Bureau of Vital Records was created, with Leo A. Ozier as its chief. All statistical functions were transferred to the Division of Health Planning and Resource Development, and the Bureau of Statistics ceased to exist. The new Bureau of Vital Records

became the sole unit responsible for maintaining the Statewide Vital Records Registration System, serving as the official custodian of these records, furnishing statistical input data for the department, and providing a vital records service to the general public.

The Bureau of Vital Records was short lived. With the major reorganization of 1970, the vital records function was placed in the Division of Administration whose chief was Edgar A. Diddams, M.S.P.H. Mr. Ozier remained as head of the Office of Vital Records, as well as Deputy State Registrar. (By law, the director of The Department of Public Health is the State Registrar.)

With the 1973 reorganization of the department, the Office of Vital Records again suffered the trauma of another transfer. This time, on July 1, 1973, it was transferred to the Division of Education and Information; Leo Ozier was transferred to the department's legal unit; and the chief public health educator was made Deputy State Registrar. Aaron Vangeison, a long-time assistant to Mr. Ozier, was made the manager of the vital records section.

This arrangement lasted until May 1, 1976, when the vital records section was made a separate division in the Office of Management Services. Aaron Vangeison was named chief of the division May 1, 1976, and was also appointed Deputy State Registrar.

The Division of Vital Records, with a staff of about fifty persons, is made up of the Registration and Amendment Services Section and the Certification and Support Services Section.

Since the central registration of births and deaths was established on January 1, 1916, over 25 million documents have been filed and stored in the Archives Building.The ever-increasing requests for copies of these records, nearly 100,000 in fiscal year 1977, has caused serious deterioration of many of the records due to repeated handling and copying and to age.

Several storage and retrieval systems have been studied since 1961 in an effort to cope with the problem of deterioration and fading ink, as well as to speed up issuance of copies. It was also hoped to be able to issue certificates over the counter. A number of proposals were prepared over the years, but all were considered too costly by the Bureau of the Budget and/or the general assembly.

In 1975, the Division of Vital Records began a program of microfilming all birth records, with the microfilm to be used for making copies rather than using the original documents. As of December 1, 1977, microfilm was available for all births filed since 1952. It is hoped over the next several years to have all birth records on microfilm, thereby eliminating any need to refer to the original document.

In addition to slowing down the deterioration of the original records, microfilm allowed the Division of Vital Records to render faster service to those requesting copies of records.

Through 1977, the division processed approximately 13,000 adoptions and legitimations, 21,000 corrections, 15,000 delayed birth record applications, and 430,000 new birth, death, marriage, and divorce certificates each year.

The office of vital records, since its inception, has necessarily and effectively worked closely with county coroners. In Illinois, coroners were elected with no requirements imposed concerning education or medical knowledge. Assistance in this area was frequently rendered by practicing physicians under whatever arrangements could be worked out locally. In the early 1950s, this situation began to be questioned and various proposals were put forth to improve the system.

In 1955, the 69th General Assembly established the Advisory Board on Necropsy Service to Coroners. This board was made up of three coroners, three pathologists or physicians with training in pathology, and three members with interest and ability in forensic medicine. All were appointed by the governor for terms of three years.

This board was advisory to the director of public health and worked closely with the Illinois Coroners' Association in exploring ways to improve the coroner system in Illinois.

The 70th General Assembly, in 1957, passed Senate Bill 63, which revised extensively the Coroners' Act of 1874. This amendment provided, among other revisions, that counties of more than 500,000 population (Cook County only) shall be designated as Class I counties, and those of not more than 500,000 population as Class II counties (the other 101 counties in the state). Section 10.1 of the amendment directed that "Any medical examination or autopsy conducted pursuant to this Act shall be performed by a physician duly licensed to practice medicine in all of its branches, and wherever possible, by one having special training in pathology. In Class I counties such medical examinations or autopsies shall be performed by physicians appointed or designated by the coroner and in Class II counties by physicians appointed or designated by the Director of Public Health upon the recommendation of the Advisory Board on Necropsy Service to Coroners, after the Board shall have consulted with the elected coroner."

The ostensible reason for the method of appointment in Class II counties was the relative scarcity of pathologists outside of the Chicago area. This method helped to some extent in appointing the

better qualified physicians downstate. In practice, however, the preference of the "elected coroner" was seldom overruled.

In order to provide coroners and their physicians with information concerning modern and acceptable practices, the board, in cooperation with the department, printed and distributed a series of manuals. The first, in 1961, was the *Coroners' Handbook* (revised in 1972). There followed (1) a guide for coroners physicians, (2) a guide for coroners in the administrative functions of their office, (3) a manual of necropsy techniques, and (4) a guide for pathologists on medicolegal investigation.

The Board ceased to function in 1971, but was reactivated in 1976 and continued to have a salutary effect upon the coroner system. The advocates of a medical examiner system continued their efforts to bring about such a structure.

The statistical function, like the vital records program, experienced a pillar-to-post existence. In 1961, as it had been for years, it was in the Bureau of Statistics. There were three well qualified statisticians on the staff, assisted by a number of statistical clerks and typists. The main effort of this group was the preparation of an annual vital statistics summary (mortality and morbidity) supplemented from time to time by special releases carrying current data on vital events; the preparation of special tabulations for students, research workers, and health agencies; and the provision of consultive and related technical statistical services to program directors and health agencies. The annual report, entitled "Vital Statistics in Illinois" (begun in 1958), contained detailed county and large-city vital statistics and was proving effective in reducing the number of individually prepared replies to inquiries received by correspondence.

These activities remained relatively constant over the next few years, with increasing demands for field studies and surveys of local area health problems; for population estimations and projections between federal censuses; and for time–cost studies for nursing services.

On March 1, 1969, the statistical function was transferred to the Division of Health Planning. In this setting the demand for statistical determinations of community health needs and attitudes increased substantially.

The statistical function was again transferred with the reorganization of 1970. The Division of Health Planning was necessarily abolished in the department when the planning function was transferred to the governor's office and statistical activities were placed in the Division of Administration where they were grouped into a

section called Health Data Analyses. The duties of the section remained the same.

Early in 1972, the section was transferred to the office of the chief of the Bureau of General Administration. With the establishment of the State Center for Health Statistics in 1974, the staff of the Health Data Analyses Section was transferred to that unit, which is a part of the Office of Planning.

Training

The department has long been engaged in training activities. Its efforts over the years have been directed to three main areas where training has been a recognized need.

The first of these has been inservice training. The purposes of this type of training have been to improve the performance of employees, to prepare employees to qualify for future advancement (thereby creating a reservoir of capability), and to meet a constant shortage of available public health specialists.

The second area has been preservice training. This effort has been directed toward individuals who would qualify for employment except for lack of a master's degree in public health or in an allied field. Requirements of numerous positions in the department, especially those at the higher levels, call for a master's degree in public health: public health physicians, public health nurses, public health educators, and others.

The third training area covers individuals not employed, nor to be employed, by the department, but who are employed in, or are to be employed in, a capacity that contributes to public health.

The training involved was for credit (academic) or no credit (nonacademic). For a time, it was required to be job-oriented, but this was later broadened.

As important as training was considered, the department has never established a central unit devoted exclusively to training, nor has it ever employed a director to supervise all training. Instead, it depended upon its bureau and division chiefs to recognize the need for training and assigned the title of coordinator of training to a member of the staff who was in a position to make decisions for the director. During the Yoder administration, this was the chief of General Administration (and assistant to the director) whose budget contained the training funds. To assist the coordinator, there was a department training committee. Although the membership of the committee changed from time to time, it usually consisted of the

chief sanitary engineer, the chief public health nurse, the chief of local health services, the chief public health physician concerned with medically-oriented programs, and the chief public health educator. In addition to screening training applications based on public health needs, available funds, and the applicant's apparent potential, the committee, with the director's approval, established and/or revised standards, determined acceptable training facilities, and established limits of allowable stipends, tuition, and fees.

For years, the department had been led to believe that state funds could not be appropriated for training purposes; so federal funds were depended upon for this purpose. However, a thorough study of the statutes and the State Constitution revealed no such limitation. The department therefore included an item for training in one of its biennial budget requests and was pleasantly surprised when the appropriation was approved. However, a legislative committee, intent upon uniformity with the training problems of the Department of Mental Health, made the utilization of the funds so complex and so limited that the department abandoned the idea of using the appropriation for fear of subsequent legislative displeasure.

Funds used almost exclusively were those characterized as "General Health"; and later on as "314d," both federal. Since neither of these were categorical in character, they were much in demand as supplementary to limited state funds. As a consequence, whenever another activity or program found itself in need of funds toward the end of a fiscal year, the training budget was considered as the ace-in-the-hole for rescuing the financially-troubled operation. This sacrificial transfer of funds frequently plagued the training effort.

This training arrangement continued until the reorganization of 1973, when the chief of the Division of Education and Information was made responsible for coordination of the department's training program.

Although figures are not available, it is estimated that approximately 4,000 individuals have been recipients of department financial assistance for training during the period of this history. The lion's share of training assistance went to nurses, although considerable sums were invested in the training of public health physicians, dentists, educators, engineers, sanitarians, school nurses, administrators, technicians in various categories, and clerical personnel.

Outside of this main training effort, each division provided training opportunities from time to time in the form of special workshops and attendance at meetings of allied societies and associations. The Division of Laboratories carried out a training program for its employees and outside laboratories. The Division of Nursing was

appropriated, for a period of a few years, an additional sum in contractual funds for the public health training of student nurses. The Division of Local Health Services maintained a special program known as "Medical Residencies in Public Health" for academic and field training to qualify physicians for positions as directors of local health departments. This program is described in the section on "Local Health Services."

By 1977, the department training program and the philosophies governing its operation had not changed appreciably. The average annual training budget amounted to about $28,000 and was expended for academic and nonacademic training for employees of the department and local health departments, as well as for attendance by department employees at job-oriented workshops. Stipends for advanced academic training leading to a master's degree in public health had been discontinued.

Affirmative Action—Equal Employment Opportunity

This activity relates to the planned, aggressive management program designed to eliminate and prevent discrimination in state service because of race, color, creed, national origin, sex, age, physical handicap, or disability and to promote the full realization of equal employment opportunity.

This was followed on June 17, 1964, by a questionnaire from the governor requiring completion to determine the number of minority employees in the state government workforce, the levels of jobs held, and the areas where efforts were necessary to better the situation.

Then, on December 29, 1964, the federal Department of Health, Education, and Welfare, through its regional health director, advised the Department of Public Health of the actions that must be taken to implement Title VI of the federal Civil Rights Act. Noncompliance after January 3, 1965, could have been cause for withholding federal funds applied for *after* that date. Among the actions required were (1) a statement of compliance with all federal regulations regarding the operation and methods of administration of department programs supported by the Public Health Service or the Children's Bureau, and (2) statements of assurance from all recipients subsidized *in any way* through the department that they would comply with the Civil Rights Act. The department was made responsible for notifying such recipients and for obtaining their statements of assurance. The department was also made responsible for notifying clients, potential clients, and the general public that the services

available were provided on a nondiscriminatory basis and of their right to file a complaint with the department or federal government if they believed that discrimination was being practiced. This was done through the preparation and distribution of a special brochure, through the *Illinois Health Messenger*, through the press, and by word of mouth.

On February 1, 1965, the Division of Local Health Services notified all local health departments of the need to complete and return form H.E.W.–441, "Implementation of the Civil Rights Act," by February 9, 1965.

The director, on April 9, 1965, advised all units of the department of the Methods of Administration of the Civil Rights Act to which he had committed the department and directed compliance by all offices, agencies, and individuals. This was followed by an addendum on April 29, 1965, to satisfy the federal request for more specificity.

The brochure, entitled "Fair and Equal Practices in the Provision of Public Health Services to the People of Illinois," was distributed statewide in September, 1965.

All of these actions formalized the practice and policy of the department regarding nondiscrimination. Its job, henceforth, was monitoring, correcting discriminatory situations, receiving and acting upon complaints, amending policy to cover unforeseen circumstances, and issuing a continuum of reminders to comply.

On December 12, 1967, a revised directive on Methods of Administration was issued to all units of the department, local health departments, and project agencies. This contained added information concerning the state's health planning function. Governor Kerner, in compliance with Public Law 89–749, "Comprehensive Health Planning," had designated the department as the sole agency for administering or supervising the administration of the state's health planning function. The function carried with it the requirement that all agencies and organizations cooperating in planning must also be in compliance with the Civil Rights Act.

On July 27, 1971, the bureaus and divisions were notified that the director's office and the federal Office of Civil Rights had agreed to a survey of the department and of the agencies in Cook, Sangamon, and Peoria Counties receiving federal funds from the department. The objectives were to (1) strengthen Title VI performance, (2) give training and assistance in the evaluation and maintenance of compliance, (3) provide technical assistance and advice, (4) identify achievements and progress, and (5) identify areas of noncompliance and formulate steps for correction. The survey was made in Septem-

ber, 1971. No actual violations of equal employment or delivery of health services were found.

In 1970, the Intergovernmental Personnel Act came into being. The Equal Employment Opportunity Act was passed in 1972. Federal Executive Orders 11246 and 11375 were also issued in 1972. To initiate compliance with these directives, the department found it necessary to take the following steps:

1. Establish an Equal Opportunity and Services Section in the office of the chief of the Bureau of General Administration to plan, coordinate, and implement all matters concerning Equal Employment Opportunity, Affirmative Action, and Title VI.
2. Establish an Equal Employment Opportunity and Services Advisory Committee to assist in development and implementation of the program.

The committee was made up of department employees—William H. McCain, M.P.H., Chairman; Robert G. Hedges, Technical Secretary; Dorothy Friedman, Robert Stout, Richard Tate, and Donovan Vance. The Department of Personnel liaison served in an ex-officio capacity.

One of Doctor Lashof's first directives dealt with policy concerning Affirmative Action. On March 21, 1973, she reiterated the department's full compliance with nondiscrimination regulations and added "physical handicap" to race, religion, color, national origin, and sex.

Governor Walker, on May 3, 1973, instructed the director of the Department of Personnel to implement a statewide Affirmative Action Program and to monitor agencies under the governor to assure compliance and progress. The Department of Personnel director requested the designation of an affirmative action officer, and Robert E. Stout was so named on May 31, 1973. Along with this move, the affirmative action plan was rewritten, and the Equal Employment Opportunity and Services Committee was temporarily deactivated pending guidelines from the Department of Personnel.

By October 30, 1973, the director of the Department of Personnel had employed a director of the Affirmative Action Program and had issued the "Affirmative Action Plan for Fiscal Year 1974." In compliance with Governor Daniel Walker's Executive Order Number 9, dated October 19, 1973, the plan called upon each agency involved to—

1. "Set forth a detailed and uniform method by which agencies shall identify existing inequities in hiring, promotion, and all

other conditions of employment based on race, religion, sex or national origin;
2. Provide specific guidelines for remedying such inequities and establish the time periods for the accomplishment of these remedial measures;
3. Establish reporting procedures for measuring agency progress and evaluating the performance of agency officials in meeting their affirmative action objectives; and
4. Contain such other requirements as the Affirmative Action Division (of the Department of Personnel) deems necessary and advisable to achieve the purposes of this Order."

The plan was obviously quite broad, lacking the kind of detail required of the department by federal regulations. It did, however, add a few new parameters and, for the first time, represented a coordinated effort at affirmative action at the state level without the necessary involvement of federal funds.

The governor's amended Executive Order of May 1, 1974, added the words "or by reason of any handicap"—an action taken long before by Doctor Lashof.

On February 21, 1974, Doctor Lashof appointed Dorothy Friedman, an employee experienced in personnel management, as the affirmative action officer for the department and liaison with the Affirmative Action Division of the Department of Personnel. A comprehensive affirmative action plan was prepared and later, on October 7, 1974, approved.

A new Affirmative Action Advisory Committee was appointed by the director on November 19, 1974, consisting of ten persons who were required to meet at least quarterly.

The department's affirmative action officer, in preparing her annual report for fiscal year 1974, made an analysis of the status of the workforce based on December 31, 1973, data. It was determined that—

1. White employees made up 81.5 percent of the workforce; nonwhite 18.5 percent. This compared favorably with Illinois labor force distributions.
2. Distribution of male employees (46.8 percent) and female employees (53.2 percent) was about equal.
3. White male employees dominated the higher pay grades.

It was also reported on August 4, 1975, that 21.0 percent of all "new hires" during calendar year 1974 were from the minority

workforce; and, during the first six months of 1975, 23.9 percent of the 109 new hires were minority members.

In keeping with the necessity for advising the state affirmative action office of progress, the department reported on November 4, 1975, on changes in its employment policies, practices, and procedures. The areas reported on were (1) upward mobility, (2) training, (3) recruitment and selection, (4) layoff, (5) qualifications, (6) complaint procedure, and (7) local health departments.

Approved in August, 1976, by the governor was Public Act 79–1441, an act making the state affirmative action office a statutory body.

A report on September 30, 1976, showed a department decrease of 45 percent in the number of black employees. This was brought about by the transfer of the Chicago Public Health Hospital and Clinics (formerly the Chicago State Tuberculosis Sanitarium) from the department to the University of Illinois. The Chicago hospital had a minority workforce of 66 percent.

On September 14, 1976, a form and procedure were adopted whereby each interviewer of candidates for employment or for upward mobility was required to give the reasons for not selecting a minority applicant to the department affirmative action officer.

From February 24 to 27, 1976, a joint Federal/State Compliance Review of the department was conducted by representatives from the U.S. Department of Health, Education, and Welfare, the U.S. Civil Service Commission, and the Illinois Affirmative Action Office. In addition to interviewing key management staff and supervisory personnel, fifty employees, chosen at random, were also interviewed. On July 15, 1976, the department received word that its plan "generally" met the guidelines; yet also received ten recommendations for improvement.

By December 31, 1976, the Department of Public Health workforce was reflected by the following table:

On February 11, 1977, the department was notified by the United State Civil Service Commission that the Affirmative Action goals and timetables had been approved. Shortly thereafter, on March 23, 1977, the department advised the governor's office of its affirmative action goals for 1977 as follows:

1. Increase utilization of minorities through employment of at least 15 percent of the new hires in all categories.
2. Continue monitoring all personnel transactions to insure that equal employment opportunity is afforded all applicants and employees.

3. Develop a recruitment brochure for distribution to high schools, colleges, and recruiting agencies.
4. Continue efforts to hire the severely handicapped and hire at least three by the year's end.

As far back as 1973, the Federal Rehabilitation Act was passed and included in section 504, a prohibition against discrimination in the case of handicapped persons. Section 504, however, was so general that it was not until April of 1977 that the Department of Health, Education, and Welfare issued specific regulations to implement that section. The regulations were far-reaching and comprehensive, covering "the blind, the deaf, persons confined to wheelchairs, the mentally ill or retarded, and those with other handicaps." On July 8, 1977, Doctor Peterson signed the "Assurance of Compliance with Section 504 of the Rehabilitation Act of 1973, as amended."

Included herein as a table containing a workforce analysis relating to all employees of the department as of February 28, 1977. There is also a comparison of the workforce compositions in 1973, 1974, 1976, and 1977.

	Male	Female	Total	Percentage of Total Department Employees	Statewide Minimum Goals
White	471	499	970	90.1%	
Black	21	65	86	8.0%	12.5%
Spanish	9	3	12	1.1%	4.8%
Oriental	5	2	7	.6%	.9%
American Indian	1	1	2	.2%	.2%
	507	570	1,077	100.0%	18.4% Minorities 35.89% Women
Illinois Department of Public Health Minorities—9.9%					

It is evident from the tables that yeoman efforts have gone into the program for eliminating discrimination at all levels of government. It can also be seen that substantial progress has been made since the program began.

In order to better understand the problem and to appreciate the extent of effort required, the following is a list of laws and orders with which the department has had to comply.

ILLINOIS DEPARTMENT OF PUBLIC
WORKFORCE COMPOSITION AS OF 2-28-77

			Male		*Female*	
	Number of Employees in Dept.	Percentage of Total Dept. Employees	Number of Male Employees	Percentage of Total Dept. Employees	Number of Female Employees	Percentage of Total Dept. Employees
White	952	88.7%	460	42.8%	492	45.8%
Black	92	8.6	21	2.0	71	6.6
Spanish American	10	.9	9	.8	1	.1
Asian American	6	.6	4	.4	2	.2
American Indian	3	.3	2	.2	1	.1
Other	10	.9	6	.6	4	.4
TOTAL	1073	100.0%	502	46.8%	571	53.2%

Total Minorities.....111 *Percentage of Minorities in Department Workforce*.....10.3%

1. Equal Pay Act of 1963
2. Age Discrimination Act
3. Executive Order 11246 (Federal)
4. Revised Order No. 4 (Federal)
5. Article I, Section 17, 18, 19, Illinois Constitution
6. Title VI, Civil Rights Act of 1964
7. Rehabilitation Act of 1973
8. Executive Order No. 9 (Illinois)
9. P.A. 79-1441 (Illinois EEO Act)
10. P.A. 77-1342 as amended (Illinois Fair Employment Practices Act)

COMPARISON OF STATEWIDE MINIMUM GOALS (ESTABLISHED BY THE STATE EEO OFFICE) FOR MINORITY GROUPS AND MINORITY PERCENTAGES IN DEPARTMENT OF PUBLIC HEALTH

	State-wide Goals	Dec. 31 1973	Dec. 31 1974	Mar. 31 1975	Mar. 31 1976	Mar. 31 1977
Total Number of Employees		1075	1165	1166	1042	1054
Black	12.5	15.1	15.1	15.0	7.5	8.6
Spanish American	4.8	.5	.2	.2	.7	1.0
Asian American	.9	1.7	1.7	1.4	.8	.9
American Indian	.2	0	.2	.1	.1	.1
Percentage Total	18.4	17.3	17.2	16.7	9.1	10.6
Women	35.89	53.2	54.0	54.3	52.7	53.6

Note: Above figures do not include employees who are now categorized as Asian or Pacific Islander, who were previously classified as "white." This would increase the minority percentage by at least 0.5%.

Local Health Services

In 1961, one division of the department, Local Health Services, was responsible for the administration of the regional offices and for matters of administration affecting the local health departments in the state. Charles F. Sutton, M.D., M.P.H., was its chief and had been since June 1, 1948.

On paper, and as reflected by the organizational chart, all communications and other dealings with the field were channeled from the various program divisions, through the Division of Local Health Services, to the regions, and, if appropriate, thence to local health departments. This system was for many years considered to be the one that could best coordinate field activities, promote the "team" concept, and eliminate "vertical" administration—"horizontal" administration being the sought-after approach at that time. In practice, the system was substantially different. Program and division heads,

who were assigned statutory responsibilities, preferred to deal directly with their representatives and specialists in the regional offices rather than go through the Division of Local Health Services and its regional health officers. The claim was made that time was wasted and that the system was a bottleneck to accomplishment. However, the programs emanating from Springfield and utilizing the medical services of the regional health officers (all physicians in 1961) generally followed the pattern shown on the organizational chart.

In addition to the two major responsibilities mentioned above, the division was responsible for (1) administering state and federal grants-in-aid to local health departments, (2) developing and assisting in maintaining minimum qualifications for the professional personnel employed by local health departments, (3) assisting in the maintenance of performance standards for local health departments, (4) administering the training program of Medical Residencies in Public Health, (5) supervising a reporting system for services performed by local health departments, (6) administering the Medical Self-Help Training Program, a civil defense effort, (7) promoting local efforts to establish county health departments through the Statewide Public Health Committee, and (8) a number of miscellaneous activities relating to local health departments.

In the reorganization of 1970, the Division of Local Health Services had its name changed to Local Health Administration. It was placed in the Bureau of General Administration, thereby losing the prerogative of reporting directly to the director and also losing its responsibility for administration of the regional offices.

On May 31, 1973, Doctor Sutton retired as chief of the division after twenty-five years in that position.

During the early days of the Lashof administration, specifically in the summer of 1973, a policy decision was made to phase out the division as a separate unit and to incorporate its functions in the director's office with specific responsibility for those functions assigned to the newly-employed associate director for Health Services, Stephen King, M.D. This decision was made ostensibly to give greater emphasis and priority to local health affairs.

As a result of that decision, several members of the staff resigned or were reassigned to other areas of the department. As staff adjusted to this change, it began to consider how best to strengthen department services to local health agencies.

Beginning in October, 1973, a new concept was conceived, and it finally emerged in January, 1974: the creation of a staff position called "Regional Health Services Coordinator." This position, one for

each of the eight regional offices, would be a field arm of the director's office reporting to the director through the associate director for medical services. The duties assigned to the regional health services coordinator were enunciated in a departmental memorandum, dated January 29, 1974. The memorandum stated in part, "As Regional Representative for the Office of Health Services, each of the above designated individuals will be the focal point for communications from the field to the Office of the Associate Director and from the Associate Director's Office to the field. These individuals will be responsible for disseminating information and communications, such as department directives and memorandum and office memos and all other communications from Springfield, to all staff administratively responsible to divisions and programs now within the Office of Health Services." (This office had its name changed from "Medical" Services to "Health" Services with the reorganiztion of January, 1974.) "Effective immediately and until further notice all communications from Springfield to the Regional Offices relative to the Department and the Office of Health Services should be routed to the individuals noted above. These individuals will also be responsible for relaying appropriate information from the Regional Offices to the Associate Director's office in Springfield."

This memorandum established the communications role of the regional health services coordinators. In March, 1974, it was established that these coordinators would be the contact point for all health-related activities in their respective regions. Another memorandum, issued at that time, stated, "They are there to assist with program problems as well as to serve as the communication link between the Department of Public Health, local health agencies, and the State's citizens."

A third memorandum from the director recognized the need to develop a better interface between local constituents and the department through the regional health services coordinators. It established the regional health services coordinator as the key person in the regional office in matters pertaining to all divisions in the Office of Health Services and Local Health Administration, and it encouraged local health agencies to contact them on matters of concern.

It should be noted that the triumvirate arrangement for the administration of regional offices under Doctor Yoder was abandoned and that the coordinators were given no specific authority in this respect.

It was not until March 1, 1976, that local health administration received the full-time attention of one person in Springfield. At that

time the position of "Assistant to the Associate Director for Local Health Administration and Regional Development" was established, and Mrs. Shirley Reed, M.S.P.H., was appointed to it. The regional health services coordinators were placed under the direction of the new position.

The local health administration unit was assigned the following responsibilities: (1) consultation in relation to interfacing the Office of Health Services programs at the local level and development of administrative guidelines, (2) development of program standards, (3) evaluation of local health department programs, (4) assistance in preparing budgets and grant requests, (5) inservice training and continuing educational development of local health nurses and other staff, and (6) assistance in developing programs particularly as they impact on local efforts.

In addition, this unit was involved in administering a grant program for partial funding of local health department programs; promoting new local health departments; expanding existing local health department services; and working with other agencies, such as the health systems agencies, coordinating local and regional efforts to set priorities and insure that local health delivery systems meet community needs.

It should be pointed out that the bulk of these activities and functions are related to Programs of the Office of Health Services. Whether or not similar arrangements were adopted within the Office of Health Facilities and Quality Care and of the Office of Consumer Health Protection (so called at that time) is not clear. The latter, however, has always had a regional sanitary engineer responsible for all environmental health activities in a region. The Office of Management Services had only two health educators in the field, and the Office of Health Finance has never had a regional staff.

The local health administration effort, as conceived by the Lashof administration, achieved the following:

- Begun in 1975, a yearly evaluation of all local health departments, based upon "Program Standards for Local Health Departments."
- Begun in 1975, a system of program budgeting with all local health departments.
- Developed in 1976, a new funding mechanism based on per capita, program performance, and need.
- Implemented in 1976, an Affirmative Action Program at the local level.

- Established in 1976, a functioning Local Health Liaison Committee.
- Participated in the development of five new resolution health departments.
- Assisted in the referendum efforts of two resolution departments to become taxable (one-mill) departments.
- Involved local health departments in the development of health systems agencies.
- Developed revised "Minimum Qualifications for Local Health Departments in Illinois."
- Assisted thirteen health departments in qualifying for total program approval in all twelve of the basic health services.

During the Lashof administration, three counties, McDonough, Coles, and Fayette, established resolution health departments in 1966, and re-established referendum (special tax) departments in 1974.

The Peterson administration announced, during September of 1977, its staunch support of public health services provided at the local level. A major objective of the department, beginning with its successful effort in 1943 to bring about the enactment of the County and Multiple County Health Department Law (Searcy-Clabaugh, after its sponsors), has been the establishment of local health departments and assisting them in the provision of adequate or improved community health services.

In 1977, two new county health departments came into being—Hancock and Perry—although neither was operational during that year.

Early in June of 1977, a policy decision was made to move toward reassignment of all regional staff of the Office of Health Services, which will result in an expansion of the role of the regional health services coordinator to one of supervision of daily regional operations.

It appeared that such a decision had merit for one office of the department, but still left the regional office in the amorphous situation of no overall leadership representing all the offices. The utilization of regional health officers (M.D.'s) failed to function effectively, and the triumvirate reporting to bureau heads did not work. No totally satisfactory administrative arrangement has been found, as of 1977, for governmental services utilizing a field staff geographically removed from headquarters. It presents a special problem to the public health service with its numerous dissimilar programs and wide range of disciplines.

Statewide Public Health Committee

This committee was formed on June 17, 1942, as a quasi-independent promotional arm of the department. Its purpose was to promote the concept of full-time local health departments. It consisted at most times of some thirty-five members of organizations that shared the department's objective of covering the state with county and multiple-county health departments through referendum and the adoption of a special local tax for the support of such departments.

In 1961, Harold K. Fuller, M.P.H., a department employee, was the executive secretary of the committee. Benjamin Wham, a Chicago lawyer, and Mrs. John H. Armstrong of Champaign were co-chairmen, having been so appointed by the governor. Mr. Wham, having served the committee since 1943, resigned on June 26, 1972. Following Mr. Wham's resignation, the governor appointed David Meister, Jr., of Peoria, as chairman and, a short time later, Mrs. Pauline Trelease of Champaign as co-chairman.

In the general election of 1962, Whiteside, Macon, and Sangamon Counties voted on the county health department proposition. Of these three, only Macon County was successful. It began operating on May 1, 1964.

At the end of fiscal year 1964, thirty-one of the 102 counties in the state were served by seventeen single-county, two bi-county, two tri-county, and one quadri-county health departments, as well as ten urban health departments. These provided services to 72.4 percent of the estimated population at that time. However, only 44.15 percent of the population of downstate Illinois (Illinois exclusive of Chicago and the remainder of Cook County) received such services.

The Evanston–North Shore Health Department was organized in September, 1964; and, in the general election in November, Champaign County voted down a county health deprtment for the second time.

Federal funds, made available for home health services under Medicare, required the formation or use of a local agency to provide such services. This resulted in the formation of thirty-two "resolution" (no special local tax) health departments. The following counties established such departments: McHenry, Boone, DeKalb, Kendall, Grundy, Stephenson, Carroll, Ogle, Whiteside, Rock Island, Mercer, Henry, Bureau, Knox, Pike, Greene, Jersey, Christian, Bond, Livingston, Iroquois, Vermilion, Douglas, Jasper, Monroe, Randolph, Marion, Clay, Logan, Menard, Calhoun, and Wabash.

Referenda were held in Kankakee and Sangamon Counties in November, 1966, and both were defeated.

With the impetus given to the formation of local health departments by counties in order to qualify for home health services funds, the Statewide Public Health Committee became less and less active, and by July 1, 1969, when Harold Fuller, its executive secretary, retired, the department made no further effort to support or maintain the committee. The Division of Local Health Services, however, maintained its section on community health services promotion.

In November of 1970, three successful referenda for county health departments were accomplished in Tazewell, Logan, and Winnebago Counties. In November of 1971, Calhoun County joined the ranks of full-time county health departments. This was followed in November of 1972 by successful referenda in Kendall and Pike Counties.

Subsequently, as mentioned on previous pages, McDonough, Coles, and Fayette Counties established resolution health departments, and Bond, Hancock, and Perry Counties established referendum health departments.

Medical Public Health Residencies

Prior to 1961, the Medical Public Health Residency program was created and responsibility assigned to the Division of Local Health Services. The purpose of such a program was to provide physicians interested in public health an opportunity for certification in public health by the American Board of Preventive Medicine.

Physicians enrolled in an Illinois residency experience contracted to accept a position in Illinois either as a director of a local health department or with the Department of Public Health. The department provided a stipend for the period of advanced learning at an accredited school of public health and for the two-year period of field training in an approved county health department.

The director appointed a Medical Public Health Residency Committee made up of persons representing various public health disciplines such as health education, administration, nursing, and laboratory. The Chief of the Division of Local Health Services was the chairman of the committee throughout the existence of the residency program. In addition, one member of the faculty of the University of Michigan School of Public Health served as an advisor. Illinois had no school of public health at the time.

The committee was responsible for establishing requirements for a county health department to qualify as a residency area, for evaluation of applicants, for detailing the kinds and extent of experiences required in field training, and for reviewing from time to time the progress and adequacy of the resident. The director of the

local health department was responsible for the immediate supervision of the resident.

In fiscal year 1962, health departments in Cook County, DuPage County, Will County, and Peoria City and County were designated as residency areas. The following year, Will County dropped out and was replaced by Lake County. These four counties continued as residency areas throughout the existence of the program.

At no time did all four counties have a resident. Recruitment of young physicians with an interest in public health was difficult. Altogether only seven or eight physicians completed their residencies. The last resident was recruited in fiscal year 1973. Subsequently, the program was phased out because of its high cost and limited accomplishments.

Grants-In-Aid

The Division of Local Health Services administered the grant-in-aid funds provided local health departments from state and federal sources.

In fiscal year 1962, state funds appropriated for the purpose were allocated to full-time local health departments on the basis of thirty cents per capita, or one dollar for each local three dollars, whichever was the lesser amount. In addition, "special need" areas, which levied their total legal tax without raising at least ninety cents per capita, were given extra funds so that each citizen was represented in the budget by at least $1.20.

The first biennial appropriation for grants to local governments was made in 1961. This was $1,650,000 and remained at this figure until the 1967–1969 biennium when it became two million dollars. (A list of these grants is included herein.) Although sufficient at first, the increasing number of county health departments, population increases, and rising costs made it necessary to supplement these grants with federal funds of a categorical nature—chronic illness, cancer, heart, tuberculosis, home health services, medicare, and maternal and child health. The only flexible federal fund was called "general health," and this, too, was utilized to some extent.

In the spring of 1969, the department Criteria Committee completed a revised method for allocating Public Health Service bloc–grant (314d) funds to local health departments. An application for a specific program containing a proposed budget and a narrative justifying the expenditure of federal funds was required. The same method was adopted for maternal and child health funds.

The narrative required (1) statement of the health problem to be

STATE GRANTS-IN-AID
TO LOCAL HEALTH DEPARTMENTS

1961–1963 biennium	$ 1,650,000
1963–1965 biennium	$ 1,650,000
1965–1967 biennium	$ 1,650,000
1967–1969 biennium	$ 2,000,000
1969–1970 fiscal year	$ 1,473,000
1970–1971 fiscal year	$ 1,473,000
1971–1972 fiscal year	$ 1,323,000
1972–1973 fiscal year	$ 3,000,000
1973–1974 fiscal year	$ 3,000,000
1974–1975 fiscal year	$ 3,790,000
1975–1976 fiscal year	$ 3,915,700

attacked or solved and documentation that such a program served a community need, (2) objectives that would indicate the proposed program was a community-related service and would maintain or improve the current level of health, (3) methods that would show administrative and professional capability, and (4) techniques for evaluating the effectiveness and efficiency of the proposed services.

Since this plan related to the budget for fiscal year 1970, applications were due prior to July 1, 1969. The department's Program Review Committee, made up of high-level staff members in the various disciplines, reviewed some eighty-seven applications, approving sixty-four and returning twenty-three for more or better information.

This method to some extent followed the federal–state arrangement for obtaining federal funds.

In fiscal year 1973, the department added a "basic health service" grant for local health departments. The amount of grant funds awarded for basic health services was based on 80 percent of the total salary of the executive offices (up to a maximum of $20,000) and the director of nursing (up to a maximum of $15,000). The basic grant also included 10 percent of the salaries of other full-time budgeted positions for qualified nurses (not to exceed one per 10,000 population served or any fraction thereof) and qualified environmental health personnel (not to exceed one per 20,000 population or any fraction thereof). The remaining 90 percent had to be paid from local funds. This arrangement was adopted to eliminate the dividing up of personnel costs and time among numerous programs. It has been found in many instances that more than 100 percent of a person's time was recorded among the various programs.

With minor changes and revisions, the application system for

federal funds and the basic formula for state grants continued through 1974. In 1975, a system of program budgeting was begun and largely implemented by the regional health services coordinators.

Qualifications of Local Health Department Personnel

The County and Multiple County Health Department Act gave the department the authority to establish and review minimum qualifications for public health personnel employed by local health departments. This responsibility was assigned to the Division of Local Health Services.

In 1962, the minimum qualifications of 1956 were revised and became effective on July 1, 1962. The revision was accomplished by the division in cooperation with the various program directors in the department. The purpose was to maintain qualifications at a level that would assure local communities of employment of highly qualified professional and technical personnel, well-trained in public health concepts and procedures, and capable of providing quality services.

The division developed a set of personnel forms and required each local health department to complete a set for each potential employee. The forms were then reviewed in Springfield by the division and the appropriate program director to determine compliance with the minimum qualifications. Final approval required the director's signature. When this was obtained, the local health department was advised to proceed with employment.

The local health service function throughout the period of this history assisted local health departments in their recruitment efforts.

The U.S. Department of Health, Education, and Welfare required the adherence of local health departments to the department's minimum qualifications in order to be eligible for federal funds. In fiscal year 1971, a federal regulation was adopted making it necessary for a local health department utilizing federal funds to be under a merit system. In order to comply, an executive was employed in May, 1971, to work with the Illinois Department of Personnel to formulate an acceptable plan. Local health department administrators and boards of health generally opposed the idea.

By June 30, 1972, fifty-one of the fifty-nine health jurisdictions had signed the Acceptance of Merit System Standards (federal form HSM–396). The completion of the form indicated that the local health jurisdiction intended to meet Federal Merit System Standards

by accepting a statewide merit system plan or by establishing a locally-operated merit system approved by the department. Three of the eight local health departments refusing to sign the acceptance document indicated that they would request no federal funds in 1973.

The department, toward the end of fiscal year 1973, requested and received opinions from the attorney general in Illinois that clarified an unhappy situation.

The attorney general summarized as follows: "Therefore, in conclusion, it is my opinion that county or multiple-county health departments are not 'special district' within the meaning of section 1 of article VII of the Illinois Constitution of 1970; that county and multiple-county health departments do not have the statutory authority to contract for the establishment and maintenance of a merit personnel system.

"I am of the further opinion that the Department of Public Health does not have the statutory authority to contract with units of local government for the purpose of establishing and maintaining a merit personnel system for county or multiple-county boards of health. Finally, county and multiple-county boards of health acting on behalf of the county and pursuant to a county ordinance or resolution, may enter into a contract with the Department of Personnel for obtaining assistance in the administration of a merit personnel system.

"Further it is my opinion that public health districts have the authority to contract with a city or county or another public health district to carry out any function not prohibited by law or ordinance; that public health districts may contract with the Department of Personnel for the purpose of obtaining assistance in the administration of a personnel program on merit principles.

"Finally, the Department of Public Health does not have the authority to contract for the establishment and maintenance of a merit personnel system."

With these opinions as guidelines, the department acted as liaison between individual health departments and the Illinois Department of Personnel, although this did not preclude direct contact between the local health agencies and the Department of Personnel.

Standards for Local Health Departments

The project to develop standards for local health departments, begun in 1957 by the division, was completed in 1961. Study committees made up of local health department personnel and de-

partment personnel collaborated in drafting a set of standards of performance. These were sent for critical comment to all state departments of public health, to all schools of public health, and to selected personnel of the American Public Health Association. They became effective for use on July 1, 1961.

For a starting point, emphasis was placed on consultive conferences with each local health department by program directors from the department. Appraisals based upon these conferences provided guidelines on which to base future policies and practices concerning the use of the standards. At the same time, local programs were evaluated in relation to objectives, activities, and accomplishments.

Consultive conferences were a substantial addition to everyone's work load and took much longer than anticipated, continuing through fiscal year 1963.

The implementation of the standards of performance tended to place a severe burden on local health departments, in many cases requiring substantial revision of existing programs, new programs, de-emphasis or elimination of some programs, additional personnel, new or revised local ordinances, etc. Progress was slow but sure, with the department helping wherever it could and maintaining a reasonable, but firm, attitude in terms of progress toward better local health services.

In fiscal year 1967, the *Standards for Local Health Departments in Illinois* were being revised in accordance with five years of experience, changes in public health procedures, and expansion of public health technology. In 1968, the revision was completed, and distribution of the manual was accomplished early in 1969.

The program standards then came into use as a factor in determining the degree of eligibility of local health departments for grants in 1970–1971.

In 1972, Section 19 was added, dealing with local mental health programs, an activity that had recently been legislatively authorized by the general assembly.

In fiscal year 1973, it was apparent that the standards were again in need of revision. Numerous task forces, consisting of both state and local health department representatives, studied all program areas during the year. There evolved a comprehensive and explicit set of performance standards that set forth nine required programs and guidelines for pursuing fourteen other activities or services. The manual was printed and distributed in June of 1974.

As mentioned previously, a yearly evaluation based on these standards was begun in 1975.

Other Local Health Department Support Services

In addition to the preceding services relating to local health departments, the division has carried out a number of other supportive services that merit inclusion.

In collaboration with the Bureau of Statistics, the division maintained a *reporting system* for services performed by local health departments.

A *Manual of Records and Procedures* was maintained detailing methods for handling and channeling various records and information from local health departments to the department.

A clerical consultive service to local health departments was provided for a short period to advise on office practices and procedures. This service was valuable in establishing uniform office procedures, which facilitated communications between local, regional, and state offices. The service was discontinued when it became impossible to recruit a qualified person willing to travel continuously.

Numerous special reports and publications were produced from time to time to assist in some phase of local health activities. Among them were *Annual Tabulation of Average Salaries for Full-Time Local Health Departments*, *Biennial Report of Local Public Health Personnel*, *Directory of Local Full-Time Health Departments*, *Directory of Boards of Health*, *Directory of Regional Personnel*, and others.

In the area of recruitment, in addition to the program in Medical Public Health Residencies, the division endeavored, for a period of time, to locate medical students for "clerkships" in public health. The purpose of this effort was to stimulate the students' interest in public health by providing one quarter of work experience at the local level in a health department. This program failed to generate any noticeable enthusiasm among medical students and was discontinued.

Miscellaneous Programs

From time to time, programs have come along that have no specific or obvious placement in the hierarchy; therefore, they have been arbitrarily assigned to the Division of Local Health Services. Among these, the following deserve mention:

Medical Self-Help Training Program—This program was developed by the U.S. Public Health Service with the cooperation of the American Medical Association in 1961. The object of the training was to teach at least one member of every family in the United States those techniques that would aid in survival in case of accident

or injury when medical, nursing, and hospital services would not be available for a period from a few days up to two or three weeks. Such situations were envisioned as possibilities in case of natural or man-made disasters, particularly nuclear attacks when large numbers of the population would be confined to shelters.

Other organizations involved were the Illinois State Medical Society, the Office of the Superintendent of Public Instruction, and the Illinois Civil Defense Agency.

The original shipment of teaching kits was quite limited, permitting initial teaching programs in only ten pilot counties in March, 1962. Later that year, the program was extended to a total of twenty-two counties. By 1968, all counties had been organized. The response and eager participation by hundreds of state and local organizations, especially schools, resulted in Illinois leading all states in the number trained. By 1972, very close to one million persons had completed the course.

With the establishment of the Division of Emergency Medical Services, the program was transferred to that unit in August, 1972.

In 1974, U.S. Public Health Service Funds were no longer forthcoming and the program was terminated.

Health Services Referral Program for Military Rejectees—In January, 1968, this program was transferred to the Division of Local Health Services from the Division of Preventive Medicine.

This program, financed by the U.S. Public Health Service, involved the interviewing of military rejectees by two of the department's public health nurses stationed at the armed forces examining station in Chicago.

From 1966 through 1967, 22,250 rejectees were interviewed. Of these, 5,196 resulted in community level actions, and 1,905 were referred to a health care resource. Follow-up, mostly by local health departments, indicated that 633 received care after referral and 435 obtained care on their own. The estimated expenditure by the department was $210.33 per individual receiving care after referral.

In November, 1968, the U.S. Public Health Service advised that the program would terminate by the end of the calendar year. The department immediately submitted a special proposal to secure funds for calendar year 1969. On November 27, notice was received that the project was renewed through December 31, 1969.

During the first six months of 1969, 9,218 rejectees participated. Of this number, 576 resulted in community-level actions for correction, 2,852 were already under a physician's care, 2,157 declined referral service, no care was indicated for 3,203 (too tall, too short, lack of trigger finger, etc.), and 430 were excluded for administrative

reasons (declined care after counseling in local communities by rehabilitation agencies or were contact failures).

A decrease in the Selective Service System's call of youths for examination for military service after July, 1969, resulted in a drastic reduction of interviews, and the program was terminated on December 31, 1969.

Chapter 11

SIGNIFICANT EVENTS

In the course of the period 1961 to 1977, various events took place that were either related to, or had some impact upon, the department. Those considered worthy of historical recognition have been set down on the following few pages without regard for chronology.

Springfield Laboratory Fire—On the evening of August 24, 1965, the department's Springfield laboratory, located at 134 North Ninth Street, was struck by fire of unknown origin. For a time, explosions were anticipated by firemen due to quantities of highly flammable chemicals stored in the rear of the building. Fortunately, these did not occur, and the conflagration was brought under control before the entire structure burned. The total damage was estimated at something over $52,000. Since the state carries no insurance, the department received a special appropriation of $30,750 for replacement of lost equipment; and, by March, 1966, most of the items lost or destroyed had been replaced, and the laboratory was again in full operation. During the months the Springfield laboratory was inoperative, specimens were rerouted to other branch laboratories and personnel reassigned as needed.

Major Housing Changes—During the administration of Governor Stratton, the state office building was erected immediately west of the state house. Upon its completion, the department was moved from scattered locations in the state house to the fifth and a portion of the sixth floors of the new building. A first aid station was also set up on the first floor. Although the entire sixth floor had been designed and built to accommodate the Springfield laboratory, this move was disallowed because of potential malodorous possibilities in the office building.

After some twenty years of the above occupancy, the department had expanded to the point where considerably more room was

urgently needed. Doctor Yoder prevailed upon the governor to allow a move to more spacious quarters. In February of 1970, the Springfield offices of the department were moved to a complex at 535 West Jefferson Street, known as Jefferson West II, occupying the basement and first four floors of the five-story, brand-new building. The department remains at this location but with substantial additional space allocated in a sister building known as Jefferson West I at 525 West Jefferson Street.

Industrial Park Fire—On December 12, 1973, at approximately 12:30 PM, a fire broke out at the department offices and storage space housed at 4398 South Jeffory Street in Industrial Park. Although this was a flash fire, all occupants escaped without injury. Despite prompt notification of, and response by, the Springfield fire department, the structure housing the department offices was completely razed.

Offices destroyed included those of Health Economics, Tuberculosis Registry, Immunization Program, Local Health Administration, Vision and Hearing, Rehabilitation, Graphic Arts, Print Shop, and the warehouse operation of Stores and Shipping.

The equipment loss alone exceeded $520,000. Other losses, including drugs, biologics, printed materials, office supplies, and paper stock, exceeded $416,000, for a total in excess of $936,000.

The operation of the department was seriously affected, since many of the burned-out services hinged directly upon and provided support to most of the departmental programs. Through the efforts of the general services officer of the department, Mr. Schweska, and the cooperation of numerous state agencies, enough office furniture and other old equipment was obtained. A building at 1130 South Sixth Street was leased on January 15, 1974, and the destroyed offices were back in limited operation within a few weeks after the fire.

In March of 1974, warehouse space was leased at 2875 North Dirksen Parkway for the stores and shipping function after utilizing temporary space at the Illinois State Fairgrounds.

On July 1, 1974, the general assembly appropriated $323,950 for replacement of equipment and supplies (H.B.2355). The same bill also appropriated $21,400 to compensate employees and vendors for losses sustained.

The building at 1130 South Sixth Street, which was used temporarily and was never suitable, was abandoned within a few years and the offices housed therein were moved to the West Jefferson complex.

Chicago Laboratory Building—The Chicago laboratory occupied

an old athletic club building that had been converted to laboratory use for several years. It was purchased by the department in 1939 and utilized until June, 1973.

In 1959, a toxicological laboratory was authorized in Chicago and Springfield and $140,000 appropriated therefor. However, the difficulty in recruiting a qualified toxicologist postponed the new operation until midyear 1961 when such a person was found. The operation was carried on in makeshift quarters in the Chicago laboratory until a new addition was available, and operations began on December 19, 1962.

Many years of effort had been spent in vain by the department in trying to obtain approval for a new and efficient laboratory building in Chicago to replace the remodeled, ill-adapted, and maintenance-prone structure in that city. Finally, the 73rd General Assembly passed S.B.1046 declaring the construction of a laboratory office building in Chicago to be "in the public interest." This, in itself, did not insure construction of a new laboratory, but rather gave the Illinois Building Authority the sanction to proceed to employ an architect and contractors, and subsequently sell bonds, if in its opinion, the project was worthwhile and necessary. However, the Illinois Building Authority failed to act during the period established; so the 74th General Assembly enacted and Governor Kerner approved H.B.1980, which declared a Department of Public Health laboratory office building in Chicago at a cost of $7,000,000; and one in Springfield, at a cost of $3,000,000, as well as six regional office buildings for various state agencies, to be in the public interest. Also enacted was H.B.2057, which appropriated $1,422,800 to pay annual rentals on buildings declared to be in the public interest.

Construction of the Chicago laboratory building was begun in 1968. The road to completion was fraught with delays and setbacks. Sufficient funds were not forthcoming, so that only one-half of the structure could be completed while the other half remained an unfinished shell. Funds were not approved while the Bureau of the Budget (created during the Ogilvie administration) considered the idea of consolidating all state laboratory services into one major department. In the meantime, adverse publicity became rampant with one Chicago newspaper referring to the structure as a "white elephant."

Finally, in June, 1973, the main laboratory in Chicago moved into the new building (only half completed inside) at 2121 West Taylor Street in Chicago, culminating a nine-year effort since legislative authorization.

Shortly thereafter, space was made available for laboratories of

the Environmental Protection Agency and the Department of Agriculture.

The University of Illinois School of Public Health, since its establishment, had been housed in various locations temporarily and inadequately. The Walker administration made the decision to assign the unfinished half of the laboratory building to the University of Illinois for its School of Public Health. The university obtained an appropriation to complete the interior.

Other Laboratory Changes—Because it has always been the largest, the Chicago laboratory of the department has been designed as the main laboratory. For this reason, the chief of the Division of Laboratories has, in recent years, always resided in the Chicago area.

Branch laboratories in 1961 were located in Rock Island, Champaign, East Saint Louis, Springfield, and Carbondale. In July of 1971, the Rock Island laboratory was closed and its workload absorbed by the Chicago laboratory. In January of 1972, the Champaign laboratory, which had recently moved from unsatisfactory, rented quarters to an excellent, new laboratory in the Champaign regional office building, was also closed. In December of 1972, the laboratory in East Saint Louis was closed and its work divided between the Springfield and Carbondale laboratories.

In August of 1977, an effort was made to close the Carbondale laboratory, which is located on the campus of Southern Illinois University and housed in an old structure built under the Works Project Administration of the Franklin D. Roosevelt era. Community resistance to closing this laboratory accounts for its continued operation.

Elsewhere, reference was made to a bill declaring a new Springfield laboratory building to be in the public interest and allowing $3,000,000 for its construction. Ground for this structure was obtained through the Department of Public Welfare (now Mental Health) from the federal government. It was located south of Springfield and adjacent to the McFarland Mental Health Zone Center. The department and the consulting architects could not agree on style, layout, or size. Before these problems could be resolved, the bill declaring the structure to be in the public interest expired. The circumstances concerning the establishment of the Springfield laboratory at 134 North Ninth Street are told under "Administrative Services, Laboratory Highlights."

Encephalitis—Encephalitis made its first recognized appearance in Illinois in 1932. In July and August of that year, twenty-seven

persons, mostly elderly, were stricken in the town of Paris in Edgar County. A universal ignorance existed about the disease. An epidemiological study conducted by the department indicated its transmissibility. The study attempted to discover some food, insect vector, or personal contact common to the twenty-seven patients, but the results were inconclusive. The virus laboratory of the department had, the previous year, introduced a new rapid test (hemagglutination inhibition) that permitted the early detection of human cases and was responsible for identifying the Paris cases as encephalitis.

Then, in 1933, an extensive outbreak of epidemic encephalitis developed in Saint Louis and its vicinity with scattered cases in Illinois.

In 1964 and again in 1968, outbreaks of the so-called Saint Louis encephalitis occurred in limited areas of southern Illinois—forty-seven cases in 1964 and thirty-three in 1968. Following the latter, a bird and mosquito survey was conducted by the department and the Center for Disease Control (C.D.C.) of the U.S. Public Health Service in the areas where encephalitis cases had occurred. The mosquitoes and bird blood samples collected were sent to the Center for Disease Control laboratory in Fort Collins, Colorado for examination.

At the same time, a comprehensive educational program was undertaken to warn the residents of southern Illinois of the possibility of subsequent outbreaks, to advise them of symptoms and precautions, and to recommend early consultation with their physicians.

In October, 1974, it became known that more than forty suspected cases of encephalitis had been reported in Tennessee. This proximity to southern Illinois alerted the department to the possibility of an outbreak in that part of the state.

In order to be prepared for any eventuality, a rapid response team was formed by the department, consisting of an epidemiologist, a clinician, an entomologist, and an information specialist. Its job was to work with local physicians, health agencies, and the media to evaluate the problem and to assist in the development of an immediate control program.

By now, it had been established that the virus of Saint Louis encephalitis was transmitted to humans only by the bite of a mosquito (thought to be Culex pipiens) which had bitten a bird carrying the virus. It was well known that this species of mosquito lays its eggs on water that has a high organic content, often associated with decaying weeds or improper sewage disposal. It was also known that these mosquitoes are quiet during the day and

active between dusk and dawn. Thus, there became available a number of measures that could be used in the prevention and the control of outbreaks of encephalitis.

In 1975, the first case of Saint Louis encephalitis was reported from southern Illinois. Although the department had anticipated and was ready to handle an outbreak of the size and scope of the 1964 and 1968 outbreaks, no one was prepared for the epidemic of 1975, which resulted in nearly 600 cases in 67 of the 102 counties in Illinois. Almost half of the cases occurred in Cook County, an area where there never before had been any known cases of St. Louis encephalitis. This was the largest outbreak experienced by any state in history except for the 1933 episode in Missouri.

The department laboratories received and tested more than 4,500 blood specimens during the period of the epidemic.

When it became evident that the scope of the outbreak would exceed anticipated limits, Doctor Lashof expanded the response team, mobilizing a task force consisting of more than 100 public health workers. Mosquito abatement, initiated and supervised by department engineers and sanitarians, was the single most effective weapon used in combating the epidemic.

Follow-up of cases, conducted after abatement of the outbreak, showed 1,171 confirmed or probable cases and 47 deaths associated with the disease. This was well below the usual case fatality rate for Saint Louis encephalitis, which had generally been reported to be as high as 20 percent.

In order to avoid, if possible, a recurrence of an outbreak of the scope of the 1975 epidemic, the department established a Saint Louis encephalitis early warning system. Funds were authorized and an arbovirologist was employed to coordinate the early warning system. This type of specialist (in the study of mosquito-borne diseases) heads up surveillance activities throughout the state especially in early spring.

Thus, despite years of mosquito-abatement efforts, the worst epidemic of encephalitis in Illinois occurred in 1975, reaching into unprecedented areas. Hopefully, continued research and constant surveillance will contribute to more effective control than has been available or exhibited to date.

Regional Office Buildings—For many years, the department had maintained regional offices at Aurora, Rock Island, Champaign, Carbondale, and Springfield. In 1961, all of these were in rented quarters, except the Springfield regional office, which was in the state office building.

Of the seven health– and welfare-related code departments (at

that time), all maintained regional offices. However, each geographic regional division of the state was quite different and none of the departments shared common regional quarters. Only by coincidence would the regional offices of the seven departments be located in the same municipality.

On July 1, 1963, Governor Kerner issued a directive to establish seven regional offices contiguous to the seven agencies with common regions within the state. Dawn Clark, assistant to the governor, was appointed chairman of a committee composed of representatives from each of the seven agencies. The director appointed E. L. Wittenborn as the department representative.

The number of proposed regional office buildings, on the advice of the committee, was later changed from seven to six.

The 74th General Assembly passed, and Governor Kerner approved H.B.1980 declaring six regional office buildings to be in the public interest, and the implementation of the bill was turned over to the Illinois Building Authority.

The committee produced a common regional layout requiring boundary changes on the part of all seven agencies, chose the headquarters city for all six regional areas, determined the amount of office space required for each of the six regional offices, and obtained a site for each free of cost. In some cases, land was available at the site of the mental health zone centers, and in others, the municipality involved was willing to donate land.

In 1968, the Champaign regional office building, with modern laboratory facilities, was completed. In June of 1969, the building in the Springfield region was ready for occupancy.

Inasmuch as the plan called for six regional offices, the department, using only five up to that time (Aurora, Champaign, Rock Island, Springfield and Carbondale), was required to establish one more, which it did in East Saint Louis on January 2, 1968. E. E. Diddams, M.S.P.H., executive assistant in the Division of Local Health Services, was given the added responsibility of acting regional health officer for this sixth region. This office was moved into rented quarters in Collinsville in 1969.

In addition to Champaign and Springfield, building sites were chosen in Peoria, Rockford, Collinsville, and Marion. Construction of the latter two was postponed in fiscal year 1969. Peoria and Rockford were under construction and completed in June of 1970.

The regional office building at Marion, due to the postponement, was not completed until 1973. The Collinsville site was never used because Governor Ogilvie preferred East Saint Louis. However, a regional building in East Saint Louis, the sixth, never materialized.

That same year, 1973, the department's regional office at Aurora was moved into a new building in Wheaton in quarters rented from DuPage County.

By 1977, there were eight regional offices: Champaign, Springfield, Rockford, Peoria, Marion, and Chicago (all state owned) and Edwardsville and Wheaton (rented).

It should be noted that Governor Kerner's purpose in establishing common regions and offices was to facilitate the availability of services to the public and to promote cooperation among the health and welfare agencies in providing field services.

Chapter 12

APPROPRIATIONS AND GRANTS

A Brief History

Prior to 1936, the funds available for the ordinary operation of the department were appropriated for that purpose from state money. In a few instances, grants from federal sources were received. These were for special projects such as the drought in the southern counties in 1930 and the devastating flood in the same area in 1937.

With the advent of the Social Security Act in 1936, federal grants were subsequently allocated to the department on a regular basis for the improvement and expansion of public health programs. From a modest beginning, federal grants increased steadily. Between the biennium in 1935 and the one beginning in 1961, the total funds (state and federal) available to the department had increased more than twentyfold.

It should be noted that after July 1, 1969, state funds were appropriated on an annual, instead of a biennial, basis. This change-over was effected in the hope that budgets and spending could be better planned and controlled, without having to forecast the condition of the economy a year and a half or more in advance. The preparation of an annual budget did, however, at least double the time and effort expended. Today, the personnel responsible for preparing the budget no sooner complete one than it is time to start another.

Because various sessions of the general assembly have been referred to by number, it will give a better time perspective to relate these numbers to fiscal years. Each numbered session of the general assembly covers a period of two fiscal years, as follows:

72nd General Assembly, July 1, 1961 – June 30, 1963
73rd General Assembly, July 1, 1963 – June 30, 1965

74th General Assembly, July 1, 1965 – June 30, 1967
75th General Assembly, July 1, 1967 – June 30, 1969
76th General Assembly, July 1, 1969 – June 30, 1971
77th General Assembly, July 1, 1971 – June 30, 1973
78th General Assembly, July 1, 1973 – June 30, 1975
79th General Assembly, July 1, 1975 – June 30, 1977
80th General Assembly, July 1, 1977 – June 30, 1979

A history of the department requires the inclusion of appropriations and grants for completeness, for referential purposes, and for providing a chronological tracing of new programs and trends. It is understandable if this material is found wanting in reader appeal, except for those individuals with a special interest in the financial fortunes of the public health service in Illinois.

An Explanation of the Funding System

The funds available to the department come from the state of Illinois and from the federal government. Prior to the establishment of the Bureau of the Budget, the department budget was prepared in accordance with rather broad guidelines set forth by the Department of Finance. When the proposed budget met with the approval of both departments, it was set for hearing by the Illinois Budgetary Commission, made up of members of the general assembly. This commission interrogated the director of the department and his financial assistants and approved or made recommendations for change prior to introduction of the department's appropriation bill by the administration.

Since its establishment, the Bureau of the Budget works jointly with the department in preparation of the budget and reflects the governor's preliminary view on what amounts are allowable. Invariably, there are long sessions, frequently disappointing to the department, wherein the Bureau of the Budget and the department work out budget proposals for the governor's consideration. Eventually, a bill detailing the various items for which money is needed, and the amounts therefor, is introduced into the general assembly. Once in the legislative hopper, the department's appropriation bill is subject to the same scrutiny as any other bill—hearings in both the house of representatives and the senate, with their attendant testimony by the director and such aides as he may designate; three readings of the bill in both houses; and the possibility of amendments in both houses. Final approval requires the signature of the governor, who also has amending prerogatives.

Each appropriation bill states that it is an act to appropriate a

specific sum "for the ordinary, contingent and distributive expenditures of the Department of Public Health;" The term *ordinary* means "operating" and includes such major objects as "personal services" (salaries), "contractual services," "commodities," "printing," "travel," and similar items necessary to the operation of the department. This breakdown is applied to each major unit of the department.

Provision is made for specific, limited transfers of these funds on an administrative basis.

As of 1977, the department has never had to request a "deficiency" appropriation. It has, however, on several occasions, had to introduce an amendatory bill to redistribute funds without exceeding the original total or to request supplemental federal funds that became available, but were not previously appropriated by the general assembly. The latter situation, occurring in recent years only, requires the passage of an additional appropriation bill.

For many years, the department's appropriation carried a *contingency* fund to be used with gubernatorial approval for expenses that could not be anticipated, such as disasters and other emergencies. This cushion was deleted when the Bureau of the Budget was established.

Funds designated as *distributive* are those state grants and awards appropriated to the department for subsequent distribution to others. For example, since the enactment of the County and Multiple-County Health Department Act, a sum of money has always been appropriated to the department for subsidizing the operation of local health departments, using a grant-in-aid formula promulgated by the department.

Two other major categories have frequently appeared in the department's appropriation bills: *capital improvements* and *reappropriations*. The former relates to those items of major expense that improve, but do not repair. Such items, for example, have included the installation of air conditioning at a state tuberculosis sanatorium and the purchase of fixed laboratory equipment.

Reappropriations are those sums of money that were not spent during a biennium or fiscal year and are still needed for completion of a project or the implementation of a program. For example, the installation of air conditioning could not be completed at the state tuberculosis sanatorium within the period of the appropriation (for reasons beyond the department's control), so the remaining needed funds were reappropriated for completion of the project.

In addition to the regular appropriation bill, state funds are made available for new or special purposes. For example, when an "Act to Establish in the Department of Public Health, a Program for the Care

of Persons Suffering from Chronic Renal Diseases" became law, it carried an appropriation of one million dollars. After the first period of the program's operation, this sum was interwoven into the next budget and appropriation. However, funding increases or decreases may be so interwoven, depending upon experience. In recent years, there has been a tendency to continue such funds as line items in the appropriations bill.

As mentioned previously, federal funds were made available with the enactment of the Social Security Act in 1936. These funds were allocated directly to the department. Not until many years later did the general assembly require these funds to be shown in the department's appropriation bill. Thus, the administration and the general assembly were able, for the first time, to get a handle on the federal funds coming into the state.

Federal funds coming to the department were characterized as *categorical funds*. This meant that the federal government determined the major health problems of the states, appropriated funds to help overcome these problems, and distributed these funds to the states on the basis of various formulae, most of which took into account such items as population, per capita income and other socioeconomic factors. In general, the problems and programs so financed were major ones and existed in most, if not all, of the states. Among the health problems of Illinois, for which federal funds were forthcoming over the years, have been cancer control, the chronically ill and the aged, heart disease control, mental health, radiological health, tuberculosis control, water pollution control, and general health. Only the latter allowed for any discretion or decision on the part of state administrators as to the use of the money. Funds for all the others were required to be utilized categorically.

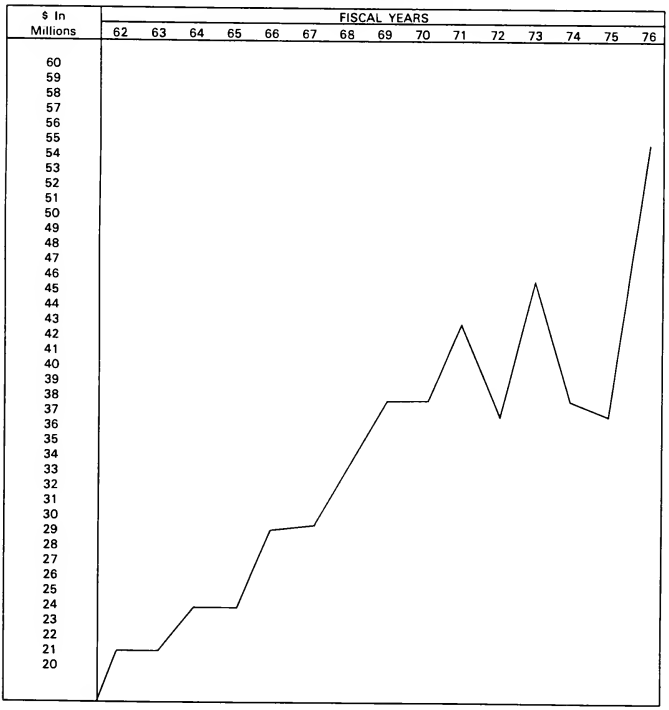
One weakness of the system was that the relationship between the amounts allocated and the extent of the problem was approximate only. Gradually, the federal government introduced and advanced the idea of grants on a project basis, wherein a detailed plan to deal with a specific problem had to be prepared and submitted for approval. Such a project proposal was required to contain objectives and goals, statistics relating to the problem, a detailed budget, population to be served, and many other components. This system was not well accepted at first. Its detractors labeled it an exercise in "grantsmanship"—the more articulate and fluent applications saying the things the "feds wanted to hear," thereby getting preferential consideration. It appears that this concern was ill-founded. However, the system also allowed for the submission of projects by agencies at

various local levels, thus bypassing the state in the long-established federal–state–local relationship.

The chart on this page provides a simple illustration of the department's financial circumstances from fiscal year 1962 through 1976. An analysis of the peaks and valleys would require another volume. The trend is remarkably upward, giving added credence to the viability of the public health effort. The chart reflects both state and federal funds available to the department and is included for those readers interested only in approximate amounts. For greater

APPROPRIATIONS TO IDPH—GENERAL ASSEMBLY
July 1, 1961– June 30, 1976

Combined State and Federal Funds
(No Adjustments for Special Sessions)



detail, the following pages show figures obtained from the Illinois Department of Finance, the Bureau of the Budget and the office of the state comptroller.

Figures for fiscal year 1977 had not been made available at the time the following resumes were prepared.

State Funds (General Revenue)

Up to 1969, state funds were made available on a biennial basis. For each fiscal year within the biennium, approximately one-half of the biennial appropriation could be expended.

July 1, 1961 – June 30, 1963 (72nd General Assembly)

Operations	$15,288,579.00
Capital Improvements:	
Landscaping Chicago Tuberculosis Sanitarium	175,000.00
Reappropriations:	
Toxicological Laboratory Service	140,000.00
Grants:	
To Local Health Departments	1,650,000.00
For Hospitalization of Persons Suffering from Tuberculosis	2,600,000.00
TOTAL	$19,853,579.00

Included in the amount for Operations are appropriations for special bills as follows:

1. $5,000 for water resources investigation in the northeastern metropolitan counties. H.B.751, approved August 24, 1961.
2. $60,000 for the registration of marriages, divorces, and annulments. H.B.1586, approved August 21, 1961.
3. $70,000 for state officers' salaries (director and assistant director). S.B.859.

July 1, 1963 – June 30, 1965 (73rd General Assembly)

Operations	$16,325,479.00
Capital Improvements:	
Chicago Tuberculosis Sanitarium—Water and Electric Supply	324,400.00
Grants:	
To Local Health Departments	1,650,000.00
For Hospitaliztion of Persons Suffering From Tuberculosis	2,600,000.00
TOTAL	$20,899,879.00

Included in the amount for Operations are appropriations for special bills as follows:

1. $50,000 for air pollution control. S.B.733, approved August 19, 1963.
2. $30,000 for maintaining a registry of film badge monitoring records and regulating film badge monitoring services. S.B.837, approved August 28, 1963.
3. $30,000 for registration of clinical laboratories, blood banks, and blood bank depositories. S.B.1103, approved August 21, 1963.
4. $50,000 for establishing a program concerning the disease phenylketonuria. H.B.1578, approved August 21, 1963.
5. $10,000 for mosquito control. (Appropriated for statewide use but necessarily limited in use to a limited area in southern Illinois, where persons were unable to venture outdoors without protective clothing.) H.B.1678, approved August 28, 1963.

July 1, 1965 – June 30, 1967 (74th General Assembly)

Operations	$20,419,948.00
Capital Improvements:	
Bailer at Mt. Vernon Tuberculosis Sanitarium	16,800.00
Fire Screens and Exit Doors, Chicago Tuberculosis Sanitarium	31,000.00
Reappropriation:	
Water Supply Parking Areas, Air Conditioning Mount Vernon Tuberculosis Sanitarium	259,313.95
Grants:	
To Local Health Departments	1,650,000.00
For Hospitalization of Persons Suffering From Tuberculosis	2,600,000.00
TOTAL	$24,977,061.95

Included in the amount for Operations are appropriations for special bills as follows:

1. $400,000 for an expanded program concerning the disease phenylketonuria. S.B.346, approved April 14, 1965.
2. $150,000 for a water-well construction program. S.B.640, approved August 20, 1965.
3. $120,000 for a water-well pump and equipment installation program. S.B.645, approved August 20, 1965.
4. $100,000 for a program to license and regulate the operation of blood banks. H.B.1142, approved August 23, 1965, effective January 1, 1966.

5. $100,000 for a program to license and regulate the operation of clinical laboratories. H.B.1143, approved August 23, 1965, effective January 1, 1966.
6. $25,000 for a blood-alcohol study of accidental deaths involving a motor vehicle. H.B. 1362, approved July 22, 1965.
7. $20,000 for a program to regulate the operation and maintenance of refuse disposal sites and facilities. H.B.1458, approved August 18, 1965.
8. $1,422,800 to pay rentals to the Illinois Building Authority for the Chicago laboratory building. H.B.2057, approved July 21, 1965.

July 1, 1967 – June 30, 1969 (75th General Assembly)

Operations	$31,675,074.00
Capital Improvements:	
Fixed Equipment, Chicago Laboratory	726,000.00
Fixed Equipment, Springfield Laboratory	245,000.00
Chicago Tuberculosis Sanitarium— Ventilation	30,000.00
Reappropriation:	
Chicago Tuberculosis Sanitarium Fire Protection	25,000.00
Grants:	
To Local Health Departments	2,000,000.00
For Hospitalization of Persons Suffering from Tuberculosis	2,000,000.00
TOTAL	$36,701,074.00

Included in the amount for Operations are appropriations for special bills as follows:

1. $1,000,000 for the care of persons suffering from chronic renal diseases. H.B.611, approved August 17, 1967.
2. $585,000 for water pollution control. H.B.1096, approved September 8, 1967.
3. $292,174 for a program of certification of plumbing contractors. H.B.1850, approved August 26, 1967.
4. $1,422,800 to pay rentals to the Illinois Building Authority for the Chicago laboratory building. H.B.2196, approved July 11, 1967.

July 1, 1969 – June 30, 1970 (76th General Assembly)
(The first annual appropriation.)

Operations	$18,906,597.00
Contributions to Municipal Retirement Funds (for certain local health departments)	15,000.00

Reappropriation:
Fixed Equipment, Chicago Laboratory 682,666.50
Grants:
To Local Health Departments 1,473,000.00
For Hospitalization of Persons
Suffering From Tuberculosis 1,000,000.00
TOTAL $22,077,263.50

Included in the amount for Operations are appropriations for the following special bills:

1. $75,000 for a program of hearing screening services for children. S.B.324, approved September 24, 1969.
2. $405,415 to pay rentals to the Illinois Building Authority for the Chicago laboratory building. S.B.1215, approved July 23, 1969.
3. $225,000 for air pollution control. S.B.1254, approved October 19, 1969.
4. $534,124 for water pollution control. S.B.1323, approved October 7, 1969.

July 1, 1970 – June 30, 1971 (76th General Assembly)
Operations $16,829,200.00
Grants:
To Local Health Departments 1,473,000.00
TOTAL $18,302,200.00

July 1, 1971 – June 30, 1972 (77th General Assembly)
Operations $17,444,102.00
Capital Improvements:
Fixed Equipment, Chicago Laboratory 250,000.00
Grants:
To Local Health Departments 1,323,000.00
TOTAL $19,017,102.00

Included in the amount for Operations are appropriations for the following special bills:

1. $120,000 for the sanitary control, regulation, and licensing of recreational areas. S.B.199, approved September 8, 1971. (Public Act 77–1473)
22. $30,000 for the health and safety control of, and the issuance of permits to, youth camps. H.B.794, approved September 17, 1971, effective January 1, 1972. (Public Act 77–1556)

July 1, 1972 – June 30, 1973 (77th General Assembly)
Operations $16,627,900.00
Permanent Improvements:
Air Condition the Public Health Hospital
and Clinics 250.000.00

Grants:	
To Local Health Departments	3,000,000.00
Highway Safety Fund*	2,050,000.00
TOTAL	$21,927,900.00

* The Highway Safety Fund is appropriated to the Governor's Traffic Safety Coordinating Committee with the above amount allocated to the department for emergency medical services.

July 1, 1973 – June 30, 1974 (78th General Assembly)

Operations	$17,695,275.00
Reappropriation:	
Air conditioning Public Health Hospitals and Clinics	175,000.00
Grants:	
To Local Health Departments	3,000,000.00
Highway Safety Fund	1,796,900.00
TOTAL	$22,667,175.00

Included in the amount for Operations are appropriations for the following special bills:

1. $1,004,875 for refunding fees paid under the Illinois Plumbing Contractor's Certification Act which was held to be unconstitutional by the Illinois Supreme Court. H.B.928, approved September 8, 1973. (Public Act 78–566)
2. $500,000 for the program in chronic renal disease. H.B.1056, approved September 6, 1973. (Public Act 78–566)

July 1, 1974 – June 30, 1975 (78th General Assembly)

Operations	$14,355,983.00
Awards and Grants:	
Hemophilia	465,000.00
Chronic Renal Disease	470,500.00
Ohio River Valley Sanitation Commission	11,100.00
Local Health Departments	3,790,000.00
Premature and High Risk Infants	1,724,400.00
Newly Formed Health Departments	100,000.00
Vision and Hearing	160,000.00
Tuberculosis Control	390,000.00
Medical Preparations (for free distributions)	362,700.00
Fire Compensation to Employees and Vendors	21,400.00
TOTAL	$21,851,083.00

Included in the amount for Operations is an item in the amount of $323,950 for replacement of supplies and equipment destroyed in the Industrial Park fire.

July 1, 1975 – June 30, 1976 (79th General Assembly)

Operations	$14,538,999.00
Awards and Grants:	
Hemophilia	399,500.00
Chronic Renal Disease	1,135,000.00
Premature and High Risk Infants	2,439,500.00
Local Health Departments	3,915,700.00
Local Governments for Hearing and Vision	160,000.00
Medical Preparations (for free distribution)	424,300.00
Medical Preparations (to individuals)	98,300.00
Road Fund	459,700.00
Medichek	937,450.00
TOTAL	$24,508,449.00

Federal Funds

Funds available from various federal sources have generally been allotted for specific purposes and programs. In the case of U.S. Public Health Service funds, these have usually been categorical in character to be used for such programs as cancer control, heart disease control, tuberculosis control, and venereal disease case finding. The partnership for health amendments of 1967 removed former categorical restrictions under section 314(d), which required states to submit a total plan for provision of public health services. Funds coming from the U.S. Children's Bureau have been limited to use for maternal and child health programs. Other funds, listed below, will be self-explanatory insofar as purpose is concerned.

July 1, 1961 – June 30, 1963

Public Health Service	$ 2,316,710.00
Maternal and Child Health	1,009,926.00
Hospital Construction	17,500,000.00
Hospital Construction (Reappropriation)	1,200,000.00
TOTAL	$22,026,636.00

July 1, 1963 – June 30, 1965

Public Health Service	$ 3,648,200.00
Maternal and Child Health	1,313,887.00
Hospital Construction	15,000,000.00
Hospital Construction (Reappropriation)	7,264,957.85
TOTAL	$27,227,044.85

July 1, 1965 – June 30, 1967

Public Health Service	$ 4,034,400.00
Maternal and Child Health	2,087,240.00

Hospital Construction	15,000,000.00
Hospital Construction (Reappropriation)	12,395,238.97
TOTAL	$33,516,878.97
July 1, 1967 – June 30, 1969	
Public Health Service	$ 6,934,898.00
Maternal and Child Health	15,356,560.00
Hospital Construction	15,000,000.00
Hospital Construction (Reappropriation)	2,316,594.90
Medicare	770,248.00
Armed Forces Rejectees	173,228.00
TOTAL	$40,551,528.90
July 1, 1969 – June 30, 1970	
(First appropriation on annual basis.)	
Public Health Service	$ 3,653,846.00
Maternal and Child Health	8,080,171.00
Hospital Construction	9,304,000.00
Medicare	204,282.00
TOTAL	$21,242,299.00
July 1, 1970 – June 30, 1971	
Public Health Service	$ 2,753,800.00
Maternal and Child Health	9,152,500.00
Hospital Construction	6,500,000.00
Medicare	224,200.00
TOTAL	$18,630,500.00
July 1, 1971 – June 30, 1972	
Public Health Service	$ 3,852,000.00
Maternal and Child Health	7,961,000.00
Hospital Construction	6,500,000.00
Medicare	290,200.00
TOTAL	$18,603,200.00
July 1, 1972 – June 30, 1973	
Public Health Service	$ 3,515,500.00
Maternal and Child Health	8,029,100.00
Hospital Construction	13,000,000.00
Medicare	405,100.00
TOTAL	$24,949,700.00
July 1, 1973 – June 30, 1974	
Public Health Service	$ 3,793,700.00
Maternal and Child Health	3,551,400.00
Hospital Construction	6,500,000.00
Medicare	446,700.00

Alcoholism	217,000.00
Emergency Medical Services	1,256,700.00
Family Planning	259,600.00
TOTAL	$16,025,100.00
July 1, 1974 – June 30, 1975	
Public Health Service	$ 3,917,600.00
Maternal and Child Health	5,451,500.00
Hospital Construction	3,500,000.00
Medicare	594,100.00
Alcoholism	336,600.00
Emergency Medical Services	930,800.00
Family Planning	62,100.00
Women and Infant Care	1,700,100.00
TOTAL	$16,492,800.00
July 1, 1975 – June 30, 1976	
Public Health Service	$ 4,703,200.00
Maternal and Child Health	9,565,000.00
Hospital Construction	6,500,000.00
Medicare	640,968.00
Emergency Medical Services	3,939,100.00
Women and Infant Care	5,120,200.00
Comprehensive Health Planning	864,200.00
Medical Review	320,273.00
TOTAL	$31,652,941.00

Money Available to the Department

Period	*State*	*Federal*	*Total*
1961-1963	19,853,579.00	22,026,636.00	41,880,215.00
1963-1965	20,899,879.00	27,227,044.85	48,126,923.85
1965-1967	24,977,061.95	33,516,878.97	58,493,940.92
1967-1969	36,701,074.00	40,551,528.90	77,252,602.90
1969-1970	22,077,263.50	21,242,299.00	43,319,562.50
1970-1971	18,302,200.00	18,630,500.00	36,932,700.00
1971-1972	19,017,102.00	18,603,200.00	37,620,302.00
1972-1973	21,927,900.00	24,949,700.00	46,877,600.00
1973-1974	22,667,175.00	16,025,100.00	38,692,275.00
1974-1975	21,851,083.00	16,492,800.00	38,343,883.00
1975-1976	24,508,449.00	31,652,941.00	56,161,390.00

It should be noted that these figures reflect the funds available to the department in a particular biennium or fiscal year. It is appaent, therefore, that since the department has never required a "deficiency" appropriation, some of the funds in each period were necessarily

"lapsed." Where fractions of dollars appear, this is the result of not spending allowable appropriations within the period, and indicates a reappropriation within the period of a portion of the original allotment. Each period indicated shows only the funds available during that period for expenditure.

Chapter 13

ITEMS OF ANCILLARY INTEREST

Illinois Public Health Association

The Illinois Public Health Association, the professional society for those engaged in, or interested in, public health in Illinois, was founded on December 5, 1940. Its primary objectives are to encourage the protection and improvement of public and personal health and to promote scientific education and administrative knowledge of public health.

Each year since 1940, the Association has held annual meetings in various cities throughout the state, at which scientific and general public health subjects have been presented.

The Association identifies and reviews legislation affecting public health and makes recommendations based upon its policy. It may favor, oppose, or call for amendments to pending legislation; it stimulates public health workers to inform their legislators on specific legislation; and it makes its position known by addressing resolutions to the governor, the general assembly, the director of the department, and other state officials.

Periodically, it conducts seminars and workshops on health topics of current interest and significance. For a number of years, beginning in 1967, it sponsored, with the Department of Public Health, a series of lectures known as the Roland R. Cross Memorial Lectures, featuring outstanding personalities in the health field. These included such persons as Doctor Abel Wolman, Professor Emeritus of Sanitary Engineering, Johns Hopkins University; and Doctor William H. Stewart, Surgeon General of the U.S. Public Health Service.

In 1941, the Illinois Public Health Association became an affiliate of the American Public Health Association, at which time it had 153 members. As of June, 1977, the membership totaled 993 active members.

In 1976, the executive council of the Association appointed Roger F. Sondag, M.D., M.P.H. (retired from the department a few years earlier), as executive secretary, a position long recognized as necessary for coordinating the Association's activities and business.

Illinois Public Health Association
Presidents

Arlington Ailes, M.D.*	1940–41
H. E. Babbit, M.S.*	1941–42
W. P. Shahan*	1942–44
Sumner M. Miller, M.D.*	1944–46
Howard J. Shaughnessy, Ph.D.*	1946–47
E. A. Piszczek, M.D., M.P.H.*	1947–48
Maude B. Carson, R.N., B.S.*	1948–49
B. K. Richardson, A.B.*	1949–50
Winston H. Tucker, Ph.D., M.D.*	1950–51
William J. Downer, B.S.*	1951–52
Harold M. Cavins, M.S., Ed.D.	1952–53
Mary M. Dunlap, M.A.*	1953–54
Felix A. Tornabene, M.D.*	1954–55
Ben D. Kiningham, M.P.H.	1955–56
George D. Forster, Ph.D.	1956–57
John Egdorf, B.S.*	1957–58
Louis W. Pickles, M.P.H.*	1958–59
Herman Bundesen, M.D.*	1959–60
LeRoy Davenport, D.V.M., M.P.H.*	1960–61
John Zur, D.D.S., M.P.H.	1961–62
Clarence W. Klassen, B.S.	1962–63
Thelma S. Cline, R.N., M.A.*	1963–64
Roger F. Sondag, M.D., M.P.H.	1964–65
William J. Hixon, M.S.	1965–66
E. L. Wittenborn, M.P.H.	1966–67
Irene A. Fahey, M.P.H.	1967–78
David P. Richerson, M.D., M.P.H.	1968–69
Verdun Randolph, M.P.H.	1969–70
John B. Hall, M.D., M.P.H.*	1970–71
James C. Barringer, B.S.	1971–72
Kenneth C. Rehnquist, M.T.	1972–73
John D. Thorpe, D.D.S., M.P.H.	1973–74
Richard Grabher, M.P.H.	1974–75
William Grills, M.P.H.	1975–76
Gary McCullough, B.A.	1976–77

* Deceased

Illinois Association of Public Health Administrators

This organization was the successor to the Illinois Association of Medical Health Officers. The latter was organized in 1949 with its membership limited to public health physicians with administrative responsibilities. Although public health physicians employed by the department were members, the major thrusts and policy determina-

tions were usually dictated by the directors of local health departments. Relationships between the Association and the department were almost constantly strained—the Association contending that department timidity prevented more realistic subsidy funds and the department contending that the Association and its local health officers neither assisted the department nor took any independent action to increase the "grants to local governments" appropriation. A continually worsening situation with respect to the availability of qualified physician health officers (despite the Public Health Residency Program) led the department to advocate and succeed in having the County Health Department Act amended. The amendment permitted the employment of nonmedical public health administrators with stated qualifications to direct county and multiple-county health departments, providing a licensed physician was utilized in a consulting position to advise on medical matters. Soon the number of nonmedical administrators outnumbered the medical.

In April, 1971, the Illinois Association of Public Health Administrators was organized with both medical and nonmedical administrators eligible for membership. This Association has been active and cooperative, with the result that it has a voice on some relevant department committees and has, from time to time, had a significant influence upon the general assembly. The affairs and interests of local health departments appear to be well served by this group.

Quarter Century Club

The Quarter Century Club came into being on December 7, 1949. It was organized to officially express the department's appreciation to those employees with twenty-five or more years tenure. At the first meeting, twenty-three employees qualified for membership.

Subsequently, provision was made for also honoring those who have been employed by the department for thirty-five and forty years.

The Club holds an annual banquet at which the new members are formally welcomed by the director and, at times, the governor. It is interesting to note that one director, Doctor Ronald R. Cross, became a member of the Club after almost twenty years as director and over five years as a district health officer in southern Illinois. Also noteworthy is the fact that three employees have served the department for 54 years.

On November 9, 1977, the Club had a total of 190 living members (some retired) and 43 deceased members. The Department of Public

Health has long had a record of fewer turnovers than most of the state departments, a record for which the Club must be considered partially responsible.

Presidents

Baxter K. Richardson	1950–1952
Clarence W. Klassen	1952–1954
Kirby A. Henkes	1954–1956
Enos G. Huffer	1956–1958
Chester A. Garwood	1958–1960
Ann Rosbrook Surbaugh	1960–1963
Elsie M. Stover	1963–1965
Eugene S. Clark	1965–1966
Richard S. Nelle	1966–1967
Robert M. Scott	1967–1968
Leo A. Ozier	1968–1969
Robert R. Cunningham	1969–1970
Eugene L. Wittenborn	1970–1971
Rita Chapman	1971–1972
Verdun Randolph	1972–1973
Luella McCutcheon	1973–1974
Dorothy Angwin	1974–1975
Ronald E. Favreau	1975–1976
Lester Stone	1976–1977
Bettie A. Thayer	1977–1978

Public Health Study and Survey Commission

After less than two years in office, Doctor Yoder's observations of the status of public health in Illinois caused him concern. Adequate budget was difficult, if not impossible, to obtain; local health departments were still insufficient in number; subsidy funds to encourage the formation of local health departments were inadequate; the public health laws were in need of codification; an Illinois school of public health was urgently needed; and many more problems were existent. It was obvious that solving most of the major problems would require assistance from some real "friends at court," that is, legislators in the general assembly. It was decided, therefore, that a legislative commission to study the problems might provide the needed support.

The governor's office approved the idea, and a bill was prepared and introduced into the 74th General Assembly to establish such a study commission. This was House Bill 1224, "An Act to create the Public Health Study and Survey Commission to study the public health needs, services, resources, and facilities of this state." The Commission was directed to report to the general assembly and the governor by March 1, 1967, and was appropriated $50,000.

Doctor David P. Richerson, the health officer of the Franklin–Williamson Bi-County Health Department, was appointed executive director of the Commission and served on a part-time basis.

The Commission labored long and energetically and produced a substantial report with the kind of recommendations that would probably have made the public health service in the state one of the best in the nation. There were, however, few legislators willing to convert these recommendations to legislation and to sponsor them, with the result that only three or four were ever considered by the general assembly. Those that were considered received inadequate Commission leadership (not for the want of effort) to be enacted.

Disappointment was keen, but not completely discouraging, to a number of the legislative members of the Commission. They tried again; and, on September 8, 1967, Senate Bill 1306, re-establishing the Commission, was approved by the governor. The Commission consisted of three members of the senate, three members of the house of representatives, and six members appointed by the governor. It was appropriated a mere $15,000 and directed to report to the general assembly and the governor by March 1, 1969.

William H. McCain, M.P.H., an assistant to the chief of the Division of General Administration, was loaned to the Commission, and Wayne Messick, M.P.H., director of the Adams County Health Department, was retained to author the report. The Commission got off to an inauspicious start when a struggle developed between two senators over the chairmanship.

Numerous desirable recommendations were forthcoming, some of them similar to those in the previous report. Among the major recommendations were (1) mandatory establishment of county or multiple-county health departments, (2) combining official county tuberculosis agencies with county health departments, (3) adding mental health services to the other services of a county health department, (4) organization of a graduate school of public health within the University of Illinois, (5) increased facilities and training funds for public health nurses and for developing public health nurses, (6) increased funds for air and water pollution control, (7) health and safety control of organized camps, (8) establishment of an occupational health program in the department, and (9) establishment of hearing and vision programs in the department.

Again, the Commission failed to make an impression on the general assembly. Its work, however, was not entirely in vain. In subsequent sessions of the general assembly, many of the Commission's recommendations became law, such as numbers three, four,

five, seven, and nine above. Increased funds for air and water pollution control became a reality only when those functions were transferred to the Environmental Protection Agency.

Hilleboe–Schaefer Study

In 1966, the general assembly established the Commission on State Government. That Commission secured two consultants with outstanding qualifications to study the organization and administration of the Department of Public Health and the functions of other state agencies related to the department. They were Herman E. Hilleboe, M.D., M.P.H., Lamar Professor of Public Health Practice, Columbia University School of Public Health and Administrative Medicine, New York, New York; and Morris Schaefer, D.P.A., Professor of Public Administration, State University of New York Graduate School of Public Affairs, Albany, New York.

By August 1, 1966, the consultants had completed their study and submitted a report to the Commission on State Government. Numerous recommendations were made in the areas of general organization, administrative services and controls, planning and resources development, community health services, personal health services, environmental health, laboratory services, and financing.

The director and his staff were invited to meet with the Commission to testify on the recommendations—111 in all. To facilitate testimony, the department prepared a list of the recommendations with the department's attitude concerning each. Although each recommendation was considered, the session was comparatively brief and no final actions were taken.

Later the same day, the director and the various division heads met with the consultants in the governor's conference room in the State of Illinois Building in Chicago. This proved to be a lively session with extremely frank discussion. The consultants were subjected to a first-hand display of what they had observed—"the choice is between administrative feudalism and administrative collaboration under executive leadership." The most serious objection to the study on the part of many division chiefs was the recommendation that advocated advancing the Division of Local Health Administration to an assistant or deputy directorship for Community Health Services. This proposal was advanced as a solution to "an organization pattern made up of a number of quasi-independent fragments, each dealing vertically with all the state and local elements pertaining to a particular program area." At that time, the concept of complete horizontal administration with all actions channeling through a

designated unit was becoming popular and being seized upon as a cure for separatist tendencies in public health. These tendencies are due to the inherent specialization and program differentiation of public health and abetted by the categorical nature of federal grant programs. Numerous factors, however, such as project grants and comprehensive health planning, have brought about a substantial diminution.

Actually, very few of the recommendations were acted upon by the department, the commission, the general assembly or the governor. Many of the recommendations were so sweeping or so advanced as to be rejected or neglected, although the years since have seen many of them implemented from time to time. Insofar as department organization is concerned, the major reorganization effected by Doctor Yoder in 1970 produced many of the solutions proposed by Hilleboe and Schaefer.

The Getting Report

By 1971, the financing and delivery of community health services in Illinois were still problems of serious magnitude. Counties were consistently reluctant to tax themselves or increase an inadequate tax for local health services, and the general assembly, as well as the administration, was not convinced that increased grants to local health departments should be appropriated. The department was anxious to find solutions to these problems and/or find alternatives to the existing system for the delivery of health services at the community level.

In January, 1971, a contract was effected with Vlado A. Getting, M.D., Dr.P.H., to study the Illinois situation. Doctor Getting, Chairman of the Department of Community Health Services, University of Michigan School of Public Health, had been commissioner of public health for the State of Massachusetts and an advisory member of the Illinois Medical Residency Committee.

Doctor Getting's report, submitted to the director of public health in October, 1971, covered in detail those facets relating to community health services, including populations, urbanization, health data and statistics, socioeconomic conditions and trends, health manpower, health maintenance organizations, and many more. By all comparisons, it was the most profound and enlightening study ever made of the health service situation in Illinois.

The bulk of the recommendations, however, rested at a higher level of government than the Department of Public Health for implementation. Copies were sent to such higher levels, as well as

to others of known influence, in the hope that it might be studied and acted upon. Departmental assistance was offered to the extent possible, resolutions by agencies and societies were sought, and individuals were exhorted to contact their representatives, especially in the general assembly. These and other efforts failed to produce a groundswell of interest leading to concerned effort. Here again, as in the case of the Hilleboe–Schaefer Study, many of the recommendations became reality with the passage of time, such as the increases in grants-to-local-health-department appropriations, which occurred largely through local effort.

Miscellanies

Midwifery—The 73rd General Assembly passed and the governor approved House Bill 1311, which amended the Medical Practice Act. It provided that without prejudice to licenses heretofore issued, no further licenses to practice midwifery shall be issued.

Seat Belts—The 73rd General Assembly also passed and the governor approved Senate Bill 15, which provided that after June 30, 1964, no persons shall sell any new automobile unless the front seat is equipped with two sets of seat safety belts.

Glue Sniffing—The serious and frequently fatal practice of glue sniffing, usually among youths, led to the governor's approval on August 16, 1971, of Senate Bill 537. This bill amended the Hazardous Substance Act by declaring that any glue, plastic cement, or similar adhesive product containing a solvent that releases toxic vapors or fumes that does not contain a noxious additive is a banned hazardous substance and required that glue without the additive be so labeled.

Poverty Program—This program was designed to upgrade the health services to the poor. So-called outreach workers were trained by the department to survey health conditions and attitudes of the poor (primarily the black population) in Carbondale, Rock Island, East Saint Louis, and Springfield. Assistance in the form of limited funds, training and expert consultation was provided in helping deprived communities to establish health services, as well as other social services that could contribute to better health, such as nutrition and food services, clinics, and employment. Two names stand out as giving impetus and dedicated time and attention to this program: Doctor Rosellen Cohnberg and Mr. Gordon Rude, a physician and a public health educator, respectively.

Collective Bargaining—This personnel function, provided for in the State Personnel Code, did not become formalized on a widespread basis until 1973, when Governor Walker issued Executive Order #6. Section 9(7) of the Personnel Code states that the director of Personnel is authorized "To conduct negotiations affecting pay, hours of work, or other working conditions of employees subject to this Act."

Executive Order #6, which was issued after the general assembly failed in 1973 to enact collective bargaining legislation for public employees, applies to nonsupervisory and nonmanagement employees of the 21 code departments, boards, and commissions subject to the Personnel Code.

By July 1, 1977, some 654 employees of the department were represented by five established bargaining units. Contracts between the American Federation of State, County, and Municipal Employees and the Illinois Nurses' Association exist in four units. Negotiations were, in 1977, underway in the fifth unit represented by the Illinois State Employee's Association.

The first Employee and Labor Relations unit in the department was formed in August, 1977. This unit, in the Office of Management Services, was established to oversee the administrative aspects of the new labor–management relationship and the subsequent signing of contracts. James Yuill, an employee with labor–management experience prior to employment by the department, was named to head up this section.

Drug Abuse—To relegate this vicious and epidemic problem to this section might well evoke severe criticism. Nevertheless, public health in general and the department in particular has had little impact upon the control or reduction of this problem. The only department effort unearthed by this writer took place in 1971 when the Division of Education and Information formulated a proposal entitled "Community Action Against Drug Abuse." The proposal, preceded by months of survey, was based upon education as the basic tool for solution and the community as the basic entity for implementation of corrective efforts. The project as proposed involved the department in (1) community leadership training, (2) advisory services, and (3) informational services.

The proposal was acceptable to a few communities and, with reservations, to others. Some preliminary meetings were held locally; training workshops in others.

To further motivate local action, two pamphlets and several television spots were prepared and distributed. Collaborating on the

pamphlet, "Teaching About Drug Abuse," were the Governor's Office of Human Resources, the Office of the Superintendent of Public Instruction, and the Departments of Law Enforcement, Mental Health, and Public Health.

The second pamphlet produced by the department was entitled "Getting It Together."

After a period of operation and re-evaluation, the drug abuse program was terminated for the following reasons:

1. lack of staff and financial resources for the program
2. perceived need by community groups for long-term assistance
3. involvement of other organizations in active community assistance
4. limited effectiveness of the program in stimulating community drug program activities

In spite of initial enthusiasm for preventing drug abuse, few agencies or communities have been willing to make the commitments of time, money, and social change necessary to alleviate the problem. Drug abuse remains a significant public health concern.

ACKNOWLEDGMENTS

To Doctor Paul Q. Peterson, Director of Public Health, I want to express my thanks for giving me the opportunity to prepare this segment of the history of the Illinois Department of Public Health and for giving me ready access to the facilities of the department.

As a department employee for over thirty years, it has been my good fortune to have been allowed firsthand knowledge of many of the things that took place. Memory alone, however, could not have sufficed; so I have sought and obtained the cooperation and assistance of members of the staff (too numerous to name), as well as that of a number of retired specialists. Their help has been generously given, for which I am sincerely appreciative.

In addition, it was necessary to research departmental files, annual reports, the *Illinois Health Messenger*, and other miscellaneous reports.

To Mrs. Luella McCutcheon for making many necessary arrangements; to Mrs. Louise LeVeque, Miss Sharon Ramazinni, and Mrs. Barbara Ford for their typing and duplicating efforts; and to the staff

of the Division of Education and Information for their editorial and format assistance; I express my appreciation. Also, to Mrs. Shirley Reed Randolph goes my gratitude for her interest and efforts in bringing this segment of department history to fruition.

It has been a gratifying experience to document this period in the history of an excellent organization to which I am indebted and for which I hold a deep affection.

Eugene L. Wittenborn